

TODAY'S HEALTH CENTER

230 Westcott Street, Suite 215 • Houston, Texas 77007 • 713-880-4444

PERSONAL HISTORY (CONFIDENTIAL)

Name _____ Social Security # _____

Home Address _____ Driver's License No. _____

City _____ State _____ Zip _____ Birth Date _____ Age _____

Sex: Male Female Number of Children _____ Marital Status: Single Married Other: _____

Daytime Tel: _____ Other Tel: _____ Email: _____

Name of Business/Employer _____ Type of Work/Duties _____

For Patients Under Age 18 (Please fill in the information concerning your Parent or Guardian)

Name of Parent/Guardian _____ Employment _____

Daytime Tel: _____ Other Tel: _____ Driver's License No. _____

Parent's Address _____

City _____ State _____ Zip _____

Who referred you to our office? Relative Friend Other Name: _____

Who is responsible for your bill besides yourself? Health Insurance Parent Auto Accident Insurance

Insurance Company Name? (provide copy of card) _____

Auto Insurance Company Name (provide claim info to us) _____

CURRENT HEALTH CONDITION

What is your main health complaint that brought you to this office: _____

Please list other doctors seen for this condition: _____

When did this condition begin? _____ Due to an accident? No Yes (complete accident addendum)

Medication your are now taking: _____ Reason? _____

_____ Reason? _____

Brief History of significant injury: _____

Brief History of surgeries and dates: _____

Previous chiropractic care? Yes No Chiropractor's Name & Date last seen: _____

(Please complete other side)

PERSONAL HISTORY (CONFIDENTIAL)

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, there are many conditions that respond favorably when treatment with chiropractic or nutritional supplementation increases your body's ability to function correctly. This office specializes in such treatment and if you wish such treatment, it will be offered. Please check the symptoms you presently have or that you have on a frequent basis.

Structural

- Headache
[mild] [moderate] [severe]
Neck pain
Jaw pain
Dizziness
Upper-back pain
Shoulder pain
Elbow pain
Wrist or hand pain
Numbness or tingling of
[upper arms] [hand(s)]
Mid-back pain
Rib Pain
Low-back pain
Hip pain
Pain that shoots from low-back to
[hip] [upper leg] [lower leg] [foot]
Numbness or tingling to
[hip] [upper leg] [foot]
Loss of strength anywhere
Where:
Knee pain: [right] [left]
Muscle spasms
Where:

General Energy Level

- Fatigue
Fatigue upon waking
Dizziness upon standing too quickly
Too tired to sleep
Hyperactive behavior
Depression
Spaciness
Hand tremors
Confusion
Night sweats
Heat strokes

Blood Sugar

- Diabetes
[Headache, dizziness, or Fatigue that is relieved by eating]

Cardiovascular

- Rapid heart beat
Slow heart beat
Irregular heart beat
Murmur
High blood pressure
Low blood pressure
Pain over heart
Previous heart trouble
Previous heart surgery
Poor circulation
[Varicose veins or Spider veins]
Hands & Feet are cold all the time.

Gastro-Intestinal

- Gas/bloating after meals
Pain over stomach
Ulcers
Frequent Heartburn
Nausea
Frequent Diarrhea
Frequent Constipation
Irritable bowel
Hemorrhoids
Frequent vomiting
Colitis/diverticulitis
Black or bloody stool
Gall bladder trouble

Eye, Ear, Nose, Throat

- Recurrent ear infections
Recurrent sore throats
Cold sores, fever blisters
Pain in eyes
Glaucoma
Macular degeneration
Cataracts
Diabetic retinopathy

Allergies

- Hives
Allergies
[1 season] [2 seasons] [3 seasons] [all year round]
Allergies to most everything
Food allergies

Respiratory

- Chronic Cough
Asthma
Emphysema
Recurrent head colds
Recurrent sinus infections
Recurrent bronchitis

Skin

- Dry Skin
Acne
Boils
Eczema
Psoriasis
Bruise easily

Genito-Urinary

- Too frequent urination
Discolored or foul smelling urine
Blood in urine
Recurrent kidney or bladder infections
Bed wetting
Inability to control bladder
Prostate trouble

For Women Only

- Recurrent cystitis or yeast infections
Vaginal discharge
Menstrual
[Irregularity] [Cramping] [Depression]
Pre-menstrual syndrome
Infertility
Frequent Miscarriages
Hot flashes
Currently taking
[Hormone Medication] [Birth control pills]
Lumps or cysts in:
[Breasts] [Ovary] [Uterus]
Endometriosis
Bladder leaks too easy

Is there anything else you would like the doctor to know? _____

We are required by law to maintain the privacy of, and provide individuals with, a HIPAA Notice of Privacy Practices, listing our legal duties and privacy practices with respect to protected health information. If you have any objections to the form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number. Your signature below is only acknowledgment that you have received this Notice of our Privacy Practices.

Payment is due when services are rendered, unless other arrangements have been made. There is a charge for missed appointments without reasonable notice and a \$25 charge for returned checks.

Your Signature: _____ Date: _____

Please use the following key to accurately mark the areas in which you feel the described sensations. Use the appropriate symbols and include all affected areas.

Dull: **N N N**

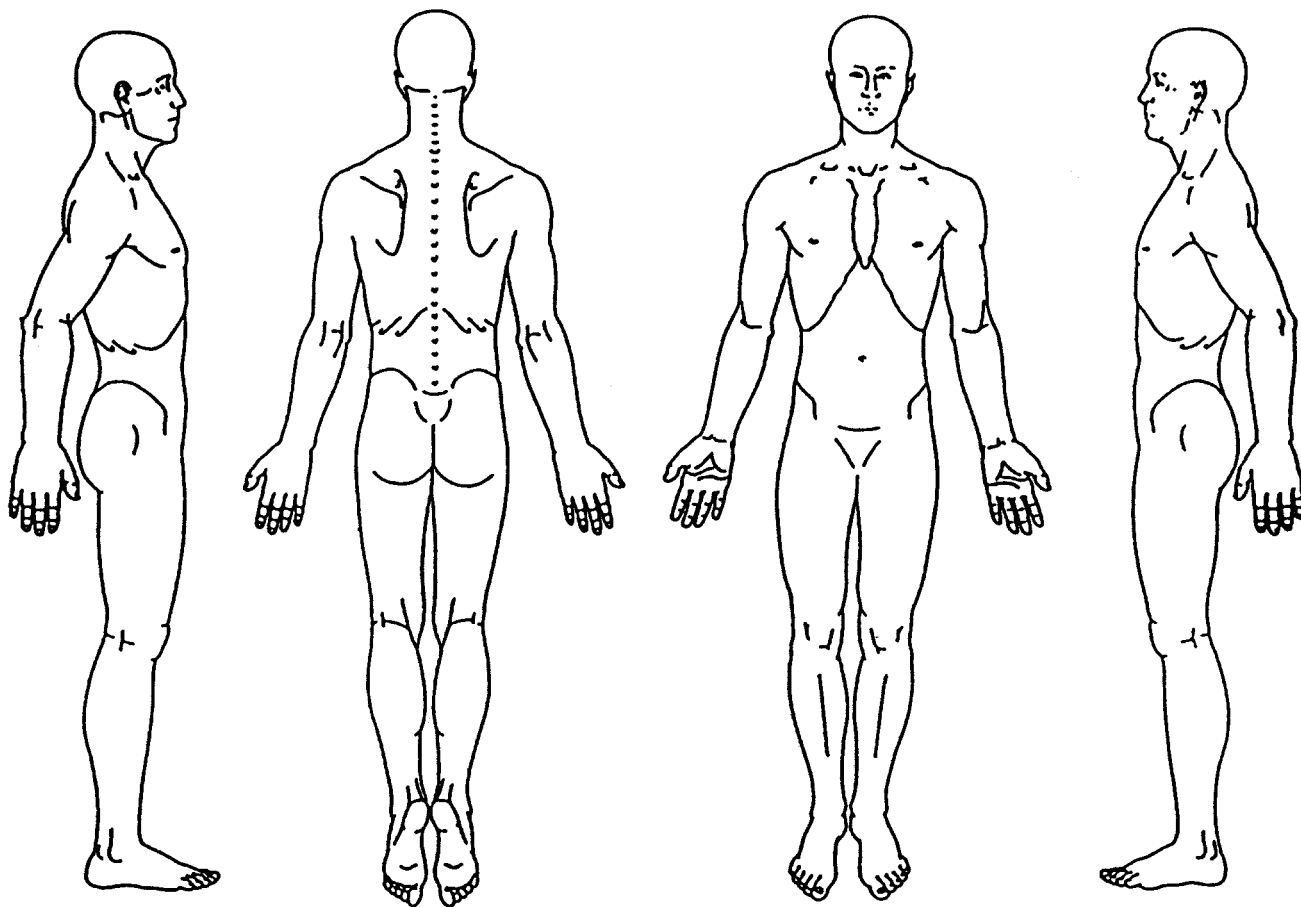
Stabbing/Cutting: **/// /// ///**

Burning: **X X X**

Numb: **= = =**

Tingling (pins & needles) **:::::**

Cramping: **S S S**



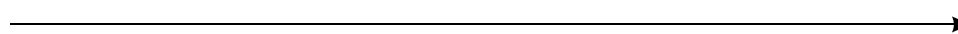
Name: _____

Date: _____

Please place one mark on the line below to indicate your present pain level:



No Pain



Worst Pain Ever