# Simmons Chiropractic Clinic
# PATIENT HISTORY & EXAMINATION

NAME_____PHONE( )_____DATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

HT._____ WT._____ AGE_____ BIRTHDATE_____MARITAL STATUS: M S W D NO. CHILDREN _____

OCCUPATION_____EMPLOYED BY_____

ADDRESS _____ CITY_____ STATE_____ZIP _____

SPOUSE'S NAME_____EMPLOYED BY_____ EMAIL_____

SOCIAL SECURITY #_____DRIVER'S LICENSE # _____

REFERRED BY _____

INSURANCE INFORMATION: (CHECK)___AUTO ACCIDENT__WORKERS' COMPENSATION__GROUP INSURANCE

_____PRIVATE INSURANCE ____WELFARE ____MEDICARE ____PERSONAL PAYMENT OTHER _____

ACCIDENT - **INJURY** INFORMATION (ONLY IF APPLIES):

DATE OF ACCIDENT_____TIME_____AM PM WAS EMPLOYER NOTIFIED'7 _____ LAST DAY WORKED? _____

ACCIDENT LOCATION & DESCRIPTION _____

PREVIOUS TREATMENT FOR THIS CONDITION:

_____DC_____MD OTHER_____NAME_____

RESULTS _____

HAVEYOU BEEN PLACED ON DISABILITY7_____BY WHOM†_____FROM_____TO _____

HEALTH HISTORY: IMPORTANT-LISTDRUGS YOUARENOWTAKING_____

DO YOU HAVE? TB_____VD_____IN THE PAST_____CANCER_____DIABETES_____

SURGERY HISTORY:

Appendix Tonsils Hernia H8morrhold Splnal Hysterectomy Prostate Cyst Cancer

LIST OTHERS_____

LIST FRACTURES / DISLOCATIONS / CONCUSSIONS PRESENT & PAST _____

LIST PREVIOUS ACCIDENTS / INJURIES / MAJOR ILLNESSES_____

FAMILY PHYSICIAN_____TELEPHONE ( )_____

ADDRESS_____CITY_____STATE_____ZIP _____

NEAREST RELATIVE (Not living with you) _____

ADDRESS_____CITY_____STATE_____ZIP_____

TELEPHONE( )_____RELATIONSHIP _____

PAYMENT ARRANGEMENTS ARE EXPECTED BEFORE SERVICE ARE RENDERED:

I understand and agree that health and accident Insurance policies are an arrangement between an Insurance carrier and myself. Furthermore, I understand that the Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the Insurance company and that any amount authorized to be paid directly to the Chiropractor Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me an that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professorial services rendered me will be Immediately due and payable

PATIENT SIGNIATURE_____DATE _____

# PATIENT SYMPTOMS COMPLAINTS

NAME_____ DATE _____

IMPORTANT:° Circle all present symptoms Underline recent past symptoms. Sign below. Be Complete.

## MUSCLE, LIGAMENT & JOINT

**NECK**: Weakness - Pain • Stiffness Swelling • Spasms - Disc - Limited Movement • Pain on Motion Surgery - Throat Muscles Swollen or Sore. Worse After Sleeping During Day • End of Day.

**MID BACK**: Weakness • Pa•n Spasms - Soreness worse After Sleeping During Day • End of Day.

**LOW•BACK**: Weakness Pain Stiffness - Swelling • Limited Movement Pain an Motion Surgery. Pain When; Setting Walking - Standing Sleeping. Worse After Sleeping During Day - End of Day. Sacroiliac • Tailbone- Sex impotency- Pain in Grain

Worse: After Sleeping During Day End of Day

## EXTREMITIES & RADIATING PAIN

**HEAD & HEADACH**E: Side - Fiona - Top - Heavy Head • Affects Vision - Produces Nausea - Throbbing• Incapacitating- Handicaps Normal Function -Migraine

Worse After Sleeping During Day End of Day

**SHOULDER:** Local Pain - Radiates Down Arm - Pain an Movement - Limited Movement Pain from the Neck

**Worse**: Alter Sleeping -During Day - End of Day.

**ARM:** Local Pain - Radiating Pain - From Neck - On Movement • Down Arm • Numbness - Tingling - Elbow • Wrist • Fingers Swelling - Heaviness - Cold Hands - Grip Strength Loss - Can't Raise • Drops Things.

**HIP. KNEES, LEGS**: Local Pain - Radiating Pain - From Back - On Movement - Down Leg- Knee {From- Back) Numbness • Tingling • Knee Swelling - Ankle swelling - Charlie Houses-Cramps Spasms - Varicose Vains - Heaviness - Pain on Walking • Sitting ' Prolonged Standing,

**FEET**: Swelling Discomfort - Pain - Pain on Walking Pain with Back Problem - Coms - Callouses- Bunions Fallen Arch High Arch • Toe in •Toe out- Cold -Burn.

### MUSCLE & LIGAMENTS

Sprain Pulled Torn - Atrophy

### SPINE & DISC

SPINE• Surgery - Arthritis - Curvature - Whiplash.

**DISC**: Surgery - Protrusion- *Compressed* • Degenerating - Deteriorating - Hern‹ated - Ruptured.

## NERVES

Burning Numbness- Tingling Pins and Needles • Tremor Nervousness - Nervous Tension • Nervous Fatigue Dizziness Poor Equilibrium - Loss of Balance

## ENERGY AND FATIGUE

Intermittent-Constant-Occasional

Exhaustion Build up - Tired Upon Awakening • Exhaust ion After Work- Must Rest During Day

**WALKING CAUSES:** Tiredness-fatigue- Exhaustion

**SLEEPING:** Good- Fair- Poor- Poor Due to Pain - Insomnia -Falls to Sleep- Emotional Fatigue - Excessive Sleep

## EYE, EAR, NOSE THROAT & MOUTH

**EYE:** Pain- Strain- Red-Blurring - Light Hurts • Double Vision-Spots- Injury- Pressure- Glasses

**SIGHT**: Far- Near- Falling- Glasses

**EAR:** Ache -Infection- Noises-Ring- Buzzing.

**HEARING**: Good- Poor- Aid- Failing.

**NOSE:** Post nasal Drip-Bleeding • Obstruction - Sneezing-No Smell.

**THROAT:** Sore- Dry-Hoarse-Phlegm- Enlarged Glands-Swallow.

**MOUTH:** Bad Taste - Teeth - Breath Gums - Sores Eruptions - No Taste

**TEETH:** Good -Bad-Abscess-Grinding •

Dentures: Fit Well - Poor

## HEART AND CIRCULATION

**HEART:** Slow- Rapid-Pain- Palpitation - Past Attack- Coronary - Chest Pain- Pain Down Arm-Difficult Breathing

**BLOOD PRESSURE-** High - Low Irregular -Past Stroke- Paralysis: L- R.

**CIRCULATION:** Good - Poor • Swelling,

**COLD**. Hands - Feet - Body - Varicose vains Hardening Arteries.

**SWEATS:** Excess- None-Hot-Cold - Night.

**BLOOD:** Problems -Disease-Anemia.

## LUNGS AND BREATHING

**LUNGS:** Difficulty Breathing • Congestion • Asthma - Emphysema • Wheezing-Bronchitis • Infection.

**COUGH:** Blood - Phlegm-Dry-Sneezing.

## STOMACH, LIVER, GALL BLADDER AND INTESTINAL

**STOMACH**: Nausea - Pain Ulcer Vomiting Blood Bile • indigestion Heartburn - Gas.

**APPETITE**:Good -Poor- Excess

**LIVER**: Upset - Jaundice -Hepatitis

**GALL BLADDER:** Attack -Infection-Stones

**INTESTINES**: Bloat- Mucous-Constipation Diarrhea -Hemorrhoids- Fissures-Colitis-IBS

## KIDNEY, BLADDER & URINATION

**URINE**- Frequent - Difficulty-Burns Blood Pus Irritates - No Control- Infection- Kidney Stones Prostate-Ovaries- Bedwettinq

## SKIN

Sensitive-Bruises- Dry- Itching-Rash-Hives Shingles - Boils- Acne- Eruptions- Slow Healing

## GENERAL

**SWOLLEN LYMPH NODES**: Neck-Underarm Groin • Face • Chills- Fever • Flu • Virus

Chronic Cold • Cough

**SINUS**: Congestion • Headache - Sneeze.

**WEIGHT**: Over • Under • Loss • Gain

**REACTION TO DRUGS**: Mind - Severe

## PERSONAL HABITS

Hours Regular Sleep/night _____

Amount of Smoking_____Pk /day

Amount of Coffee/Tea_____Cups /day

Amount Of Alcohol_____Week

Hrs. Regular worked_____Day_____Week

## FOR WOMEN ONLY

**MENSTRAL:** Cramps - Backache - Excess Flow- Difficult • Irregular - Tension.

**MENOPAUSE**: Symptoms-Hot Flashes

**VAGINAL:** Discharge- irritation Odor.

MISCARRIAGES_____PREGNANCIES_____

**Unable to Become Pregnant**. Self • Husband

**Currently pregnant**

**Due Date:**_____

Absolutely no patients accepted for diagnosis or treatment of Cancer. Suspected cases of Cancer are immediately referred.

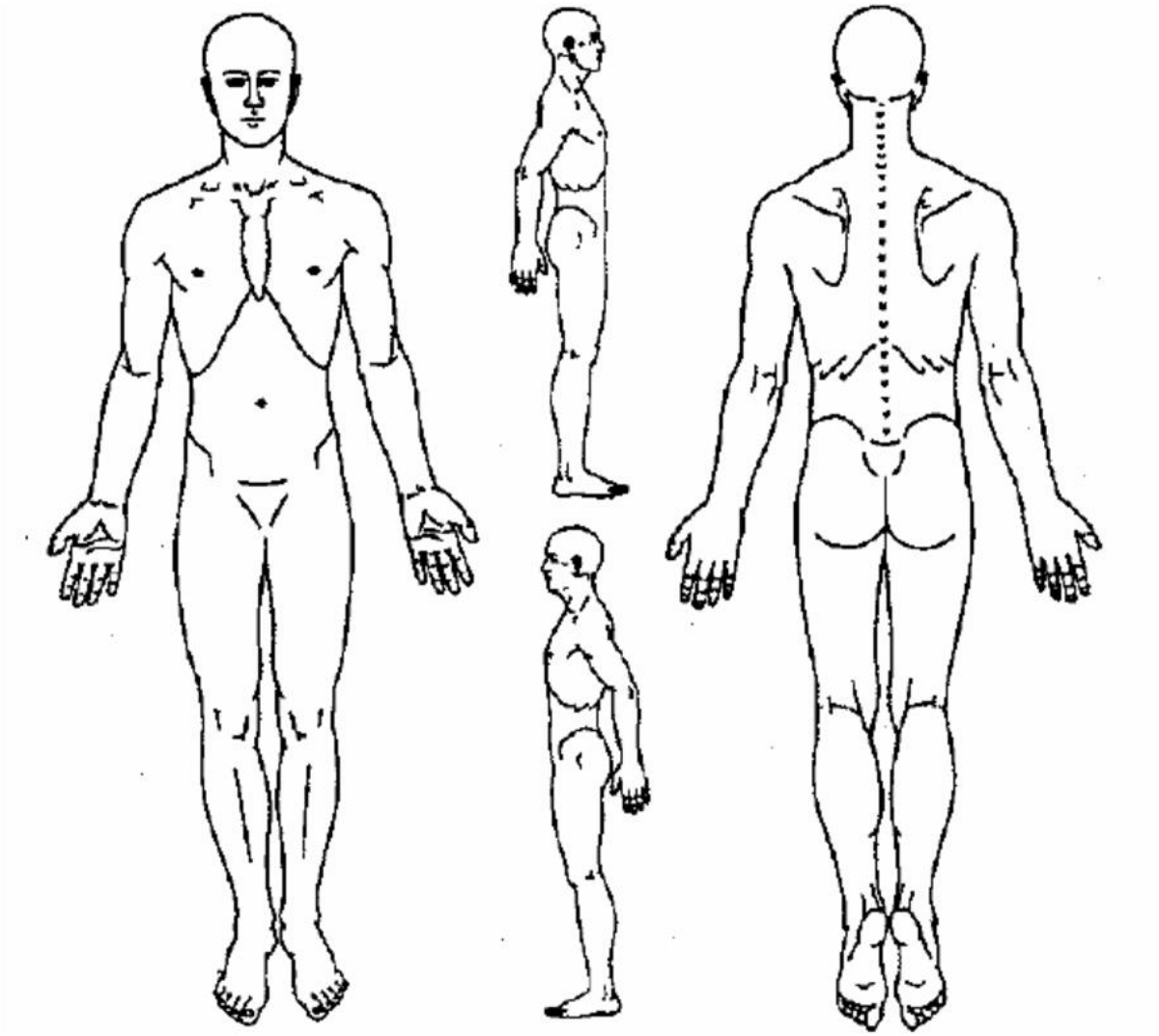
DATE _____ PATIENT SIGNATURE _____

GUARDIAN SIGNATURE _____

# Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

| Numbness | Pins & Needles | Burning | Aching | Stabbing |
|---|---|---|---|---|
| - - - - - - | o o o o o | ^ ^ ^ ^ | x x x x | ⊗ ⊗ ⊗ ⊗ |
| - - - - - - | o o o o o | ^ ^ ^ ^ | x x x x | ⊗ ⊗ ⊗ ⊗ |
| - - - - - - | o o o o o | ^ ^ ^ ^ | x x x x | ⊗ ⊗ ⊗ ⊗ |



NAME _____ DATE _____

No Pain |——————————————————————————————| Worst Possible Pain

Please make a slash through this line as to the level of your pain.

_____

Patient Signature