HARNOIS CHIROPRACTIC
AND SPINAL DECOMPRESSION OFFICE.
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CONFIDENTIAL HEALTH INFORMATION

Please allow us to photocopy you driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards. **Please print clearly.**

TODAYS DATE_____

HAVE YOU CONSULTED A CHIROPRACTOR BEFORE? Y____, N____ LAST VISIT DATE_____

HOW WERE YOU REFERRED TO OUR
OFFICE?_____

YOUR LAST NAME_____, FIRST NAME_____, MIDDLE NAME(initial)_____

SS#_____-_____-_____, DOB_____-_____-_____, AGE_____, MARITAL STATUS M S W D Separated

ADDRESS_____,CITY_____,STATE_____ZIP_____

HOME PHONE (___)_____,WORK PHONE (____)_____EXT____,CELL(____)_____

PREFERRED METHOD OF CONTACT ____HOME PHONE, ____WORK PHONE, ____CELL PHONE

IF NEEDED FOR SCHEDULING, MAY WE CONTACT YOU AT WORK? ____Y ____N

EMAIL ADDRESS_____

SPOUSES NAME_____

EMERGENCY CONTACT _____, PHONE (____)_____, RELATIONSHIP_____

YOUR EMPLOYER_____,ADDRESS_____

CITY_____, STATE____, ZIP CODE_____

PRIMARY CARE PROVIDER_____, ADDRESS_____

CITY_____, STATE____,ZIP_____, PHONE (____)_____

INSURANCE COMPANY_____, POLICY NUMBER_____

WHO CARRIES THIS POLICY? ____SELF, ____SPOUSE, ____PARENT

INSURED'S NAME IF NOT YOU_____, BIRTH DATE_____

INSURED'S EMPLOYER_____, ADDRESS_____

CITY_____, STATE____, ZIP CODE_____, EMPLOYERS PHONE (____)_____

THE MAIN SYMPTOMS THAT HAVE PROMPTED ME TO SEEK CARE TODAY INCLUDE:

_____

_____

_____

_____

IS THIS PROBLEM: ____WORK RELATED (INJURY DATE _____), ____AUTO INJURY (DATE OF ACCIDENT _____), ____NEW PROBLEM, ____RECURRING PROBLEM (WHEN WAS YOUR LAST EPISODE? _____).

WHEN DID THIS EPISODE OF PAIN FIRST APPEAR?_____, DID YOU DO SOMETHING TO BRING

ON THE PAIN?_____

PAIN INTENSITY: (PLEASE CIRCLE) 0(NO PAIN) 1 2 3 4 5 6 7 8 9 10(VERY SEVERE)

QUALITY OF PAIN: ____SHARP, ____DULL, ____ACHING, ____THROBBING, ____NUMB, ____TINGLING

HOW OFTEN DO YOU FEEL THE PAIN? ____CONSTANT, ____COMES AND GOES

DOES IT RADIATE/TRAVEL TO ANOTHER AREA OF YOU BODY? ____Y, ____N

WHERE(arm, leg, head, etc.)_____

WHAT MAKES IT WORSE? (time of day, movement, etc.)_____

_____

WHAT MAKES IT BETTER?_____

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS PROBLEM? ____Y, ____N WHEN_____

WHAT TREATMENT WAS GIVEN? (medications, injections, PT,etc.)_____

_____. DID IT HELP?_____

IS THERE ANY THING ELSE THAT DR HARNOIS SHOULD KNOW ABOUT YOUR CONDITION?_____

_____

HOW DOES YOUR CURRENT CONDITION INTERFERE WITH YOUR:

WORK/CAREER_____

RECREATIONAL ACTIVITIES_____

HOUSEHOLD RESPONSIBILITIES_____

PERSONAL RELATIONSHIPS_____

IS YOUR CONDITION: ____STAYING ABOUT THE SAME, ____WORSENING, ____GETTING BETTER

PRIOR SURGERIES/YEAR

_____	_____	_____
_____	_____	_____
_____	_____	_____

REVIEW OF SYSTEMS

PLEASE CHECK BESIDE THE APPROPRIATE ANSWER.

MUSCULO-SKELETAL/ NEUROLOGICAL	HAVE	HAD		HAVE	HAD	
	____	____	OSTEOPOROSIS	____	____	ANXIETY
	____	____	OSTEOPENIA	____	____	DEPRESSION
	____	____	KNEE INJURIES	____	____	DIZZINESS
	____	____	ARTHRITIS	____	____	PINS/NEEDLES
	____	____	FOOT/ANKLE PAIN	____	____	NUMBNESS
	____	____	SCOLIOSIS	____	____	ANOREXIA
	____	____	SHOULDER PROBLEMS	____	____	BULEMIA
	____	____	NECK PAIN	____	____	HEADACHES
	____	____	ELBOW/WRIST PAIN	____	____	LOWER BACK
	____	____	TMJ (jaw) PAIN	____	____	HIP PAIN

CARDIOVASCULAR/ RESPIRATORY	HAVE	HAD		HAVE	HAD	
	____	____	HIGH BP	____	____	ASTHMA
	____	____	LOW BP	____	____	SLEEP APNEA
	____	____	HIGH CHOLESTEROL	____	____	EMPHYSEMA
	____	____	POOR CIRCULATION	____	____	COPD
	____	____	EXCESSIVE BRUISING	____	____	ANGINA

DIGESTIVE/ SENSORY	HAVE	HAD		HAVE	HAD	
	____	____	ULCER	____	____	TINNITUS
	____	____	GERD	____	____	HEARING LOSS
	____	____	FOOD SENSITIVITIES	____	____	LOSS SMELL
	____	____	HEARTBURN	____	____	LOSS TASTE
	____	____	CONSTIPATION	____	____	BLURRED
	____	____	DIARRHEA			VISION

SKIN/ ENDOCRINE	HAVE	HAD		HAVE	HAD	
	____	____	SKIN CANCER	____	____	THYROID
	____	____	PSORIASIS	____	____	IMMUNE DIS.
	____	____	ECZEMA	____	____	DIABETES
	____	____	HAIR LOSS	____	____	LOW BLOOD
	____	____	UNEXPLAINED RASH			SUGAR
	____	____	PROSTATE ISSUES	____	____	PMS
	____	____	ERECTILE DYSFUNCTION	____	____	HAIR LOSS
	____	____	UNEXPLAINED WEIGHT LOSS/GAIN			

DISEASES	HAVE	HAD		HAVE	HAD	
	____	____	AIDS	____	____	HEART DIS.
	____	____	ALCOHOLISM	____	____	HEPETITIS
	____	____	ALLERGIES	____	____	HIV POS
	____	____	ATHEROSCLEROSIS	____	____	GOUT
	____	____	STROKE	____	____	MEASLES
	____	____	CHICKEN POX	____	____	MS
	____	____	EPILEPSY	____	____	MUMPS
	____	____	GLAUCOMA	____	____	RH. FEVER

HAVE YOU EVER HAD ANY TYPE OF CANCER? ____N, ____Y
DESCRIBE_____

DO YOU HAVE A PACEMAKER? ____N, ____Y

HARNOIS CHIROPRACTIC OFFICE
MEDICATION LIST

PRINT NAME: _____

DO YOU SMOKE (circle one): YES NO HOW MUCH PER DAY _____
HAVE YOU EVER SMOKED (circle one): YES NO QUIT DATE: _____

MEDICATION	DOSAGE AND FREQUENCY	CONDITION BEING TREATED	INITIAL FILL DATE

PLEASE LIST BELOW ANY/ALL MEDICATIONS YOU HAVE ALLERGIES TO:

MEDICATION NAME:

CONTINUE ON BACK IF NECESSARY
** With new insurance mandates, we remind you to ALWAYS bring your reading glasses to all of your appointments.

PATIENT SIGNATURE: _____ DATE: _____
DOCTORS SIGNATURE: _____ DATE: _____