Patient Health History

BASS RIVER CHIROPRACTIC

First Name ______________________________ **Middle Name** ______________________________

Last Name ______________________________ **Suffix** _______ **Nickname** ___________________________

Address ____

City ______________________________ **State** ___________________ **Zip Code** ______________

Home Phone ___________________ **Secondary** ___________________

Mobile ____________________ **Work Phone** ___________________

Date of Birth ______/______/______ **Age** ______ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** ______ - ______ - ______

Employment Status *(check one)* ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired

Race

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other ❑ I choose not to specify

Ethnicity*(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Patient Email and Text Messaging Reminders

In order to protect your privacy, no confidential or personal information will be sent from Bass River Chiropractic via email or text messaging. Bass River Chiropractic does not share the names, email addresses, and/or telephone numbers of patients with any other company, or with any other patient. Please print all information neatly and legibly.

Cell Phone # _________________________ **Provider** ____________ **Email** ______________________________
(Sprint, Verizon, etc.)

o Yes, please sign me up to receive email and text messaging confirmations.

o I do not wish to be contacted via email. (Text messaging only)

o I do not wish to be contacted via text messaging. (Email only)

o I do not wish to be contacted by either text messaging or email.

I hereby give Bass River HealthCare Associates permission to send messages to me via email and/or text messaging as means of communication as indicated by my selection above.

______________________________ ______________

Signature **Date**

Allergies

List any known allergies you have had to any medications. **If no allergies are known, check here: ❑**

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

Medications

List current medications.
Include frequency and dosage if known. **If there are no current medications, check here: ❑**

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

5. ______________________ 6. ______________________

7. ______________________ 8. ______________________

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Briefly list your main health problems: ____

____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: ______________

____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: ______ inches **Weight:** _____ pounds **BP:** ___ / ___ **Pulse:** _______

PATIENT NAME:______________________________ DOB: _____________ Date: __________

HEALTH HISTORY

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

☐ Heart attack / stroke ☐ Heart surgery/pacemaker ☐ Heart murmur

☐ Congenital Heart Defect ☐ Mitral Valve Prolapse ☐ Artificial Valves

☐ Alcohol / Drug Abuse ☐ Venereal Disease ☐ Hepatitis

☐ HIV+/AIDS ☐ Shingles ☐ Cancer ________________

☐ Frequent Neck Pain ☐ Emphysema / Glaucoma ☐ Anemia

☐ High/Low Blood Pressure ☐ Psychiatric Problems ☐ Rheumatic Fever

☐ Severe/Frequent Headaches ☐ Kidney Problems ☐ Ulcers / Colitis

☐ Fainting/Seizures/Epilepsy ☐ Sinus Problems ☐ Asthma

☐ Diabetes / Tuberculosis ☐ Difficulty Breathing ☐ Chemotherapy

☐ Lower Back Problems ☐ Artificial Bones / Joints ☐ Arthritis

Reason for your visit: ____Auto Accident ____Slip&Fall ____Work Accident
date of accident _______________ Other: ____

Have you had the same or similar condition in the past? Please describe:

____

List any previous surgeries / treatments with dates:

____

List any past serious accidents with dates:

____

Family Health History:

____

____

Do you: Take supplements or vitamins? ☐ YES ☐ NO Exercise ☐ YES ☐ NO

Are you on a special diet: ☐ YES ☐ NO if yes, since _______/_______/_______
Are you wearing: ☐Heel lifts ☐Sole lifts ☐Inner soles ☐Arch supports
FOR WOMEN: Are you taking birth control? ☐YES ☐NO
Are you pregnant? ☐ NO ☐ YES / How long? __________ Nursing? ☐YES ☐ NO

Have you ever been treated by a chiropractor before? ________ If yes, whom? ___________________

Emergency contact person: ___________________ Relation: ______________ Phone# _______________
Who is your medical doctor? ___________________________ Phone # _____________________________

Bass River Healthcare Associates
Current Complaint History

Patient Name : ______________________________ Date : ______________

Please check all boxes that apply to your condition and fill in the spaces that describe your present complaint(s). Also, the information you provide concerning past symptoms will help in assisting the doctor to better understand your present complaints and total health picture.

Please list you present complaint(s) and mark your level of pain today for each complaint
If you have more than one area of complaint, list them in order from most severe to least severe

1.) ______________ Duration – (How long / Date) : ________ # of Previous Episodes: ________
(**Please circle one**)
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

2.) ______________ Duration – (How long / Date) : ________ # of Previous Episodes: ________
(**Please circle one**)
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

3.) ______________ Duration – (How long / Date) : ________ # of Previous Episodes: ________
(**Please circle one**)
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Has anyone treated you for this episode? ☐ YES ☐ NO If yes, by whom? ______________

What makes your symptoms better?

☐ Nothing ☐ Lying Down ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Other ________

What makes your symptoms worse?

☐ Nothing ☐ Lying Down ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Other ________

Are your symptoms?

☐ Decreasing ☐ Increasing

Does your pain move or radiate?

☐ Yes ☐ No Where? ________

Check the best and worst times of the day for your pain:

Worst	Best
☐ First Awake	☐ First Awake
☐ Morning	☐ Morning
☐ Afternoon	☐ Afternoon
☐ Evening	☐ Evening
☐ Nighttime	☐ Nighttime
☐ Other	☐ Other

MARK THE LOCATION OF YOUR PAIN WITH AN "X"