Garnett Chiropractic Health History

_____ Date_____

Name _____Single/Married/Divorced

Address _____

(P.O.,Street) (City) (State) (Zip) (Spouse, Parent or Guardian)

_____

(Social Sec. #) (Medicare #) (Birthdate) (Age) (Home Phone)

Your Employer_____ Work Phone _____

Would You Like A Text Reminder of Your Appointment? Yes or No If Yes, Cell Phone Carrier_____

Cell Phone #: _____ Referred to Garnett Chiropractic by: _____

Have you been a patient of Dr. Garnett? _____Name of Prev. Chiropractor_____

Insurance Comp. _____Insured's Name (if different): _____

Insured's Birthdate_____ Deductible Amt._____ Met Deductible? _____ % Insurance Pays_____

Workman's Compensation Claim? _____ Did You Notify Employer? _____

Name/Address of WC Insurance _____

Auto Accident Claim? _____State Where Accident Occurred_____

THIS OFFICE FILES INSURANCE AS AN ACCOMMODATION TO YOU. WE ARE NOT RESPONSIBLE FOR INSURANCE REIMBURSEMENT.

SYMPTOMS OR HEALTH PROBLEMS: _____

_____

_____

_____

_____

Date Symptoms Began: _____ Have You Experienced These Symptoms Previously? _____

Do You Have Any Family History of These Symptoms? _____

CIRCLE THE LEVEL OF YOUR PAIN/DYSFUNCTION: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Mild ----------Severe

CIRCLE ANY SYMPTOMS YOU HAVE EXPERIENCED:

Headaches – Dizziness – Neck Pain – Upper, Mid, Low Back Pain – Arm or Hand Pain or Numbness – legs or Feet Pain or Numbness – Shoulder Pain – Chest Pain – Ulcers – Indigestion – Stomach Pain – Diarrhea – Constipation – Menstrual Pain – Fainting – Difficulty Sleeping – Difficulty Breathing – Diabetes – Cancer – Stroke – High or Low Blood Pressure – Heart Attack – Gall Bladder Disorder – Liver Disorder – Kidney Disorder – Prostate Disorder – Hemorrhoids – Tuberculosis – Allergies – Asthma – Nervousness – Depression – Tired Feeling – Any Other Condition:

(over)

Circle Activities That Are Limited By Symptoms. i.e.:
Sitting – Standing – Laying Down – Walking – Running – Lifting – Bending – Sleeping – Eating – Computer Use – Household Chores – Driving – Climbing Stairs – Carrying Groceries – Personal Care – Recreation – Others.
Explain: _____

_____

Slightly Limited 0-------1--------2--------3-------4--------5--------6--------7--------8--------9--------10 Unable To Perform

List Any Dr. You Have Seen For These Symptoms: _____
List Any Medications And Reasons: _____

_____

_____

Date of X-Rays & Reason: _____ Date of MRI & Reason: _____
Date of CAT Scan & Reason: _____ Date of Spinal Tap & Reason: _____
Dates & Types of Surgeries: _____

_____

_____

Broken Bones & Dates: _____ Dislocations & Dates: _____

_____

Other Tests: _____

Have You Had Any Injury Accident At Home, Work, Auto or Elsewhere? If So, Describe With Symptoms, Treatment & Date of Accident: _____

_____

_____

CIRCLE ANY RISK FACTORS THAT YOU PARTICIPATE IN: *Smoking: _____/Day – Coffee: _____/Day – Sodas: _____/Day – Fast Food: (Daily or Weekly) – Alcohol: _____/Day*

RATE YOUR STRESS LEVEL: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Calm ----------Stressful
Circle: Divorce, Job Stress, Death, Relationship, Illness, Other: _____

I UNDERSTAND THAT IT IS MY PERSONAL RESPONSIBILITY TO PAY FOR MY CARE & AGREE TO MAKE PAYMENT ON THE SAME DAY OF SERVICE.
Patient Signature: _____ Date: _____

FEMALES: Is There A Possibility of Pregnancy? _____ If so, due date: _____
Signature: _____