Welcome to Midlands Health Center

We want to take this opportunity to welcome you to our practice!

Our goal is to make your visit here as pleasant and as efficient as possible.

Please take a moment to complete the following so that we may better serve you and your family.

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms.
Full name: _____
LAST FIRST MIDDLE

Mailing address: _____
STREET CITY STATE ZIP

Home phone:( ) _____ Work phone:( ) _____ Mobile phone:( ) _____

SS#: ___ — ___ — _____ Age: _____ DOB: __/__/__ e-mail: _____
MM/DD/YY

Marital status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed Number of children: _____

Employer's name: _____

Employer's address: _____

Spouse's name and address (if different): _____

Spouse's DOB: __/__/__ SS#: ___ — ___ — _____ Spouse's work phone:( ) _____
MM/DD/YY

Spouse's employer's name: _____

Spouse's employer's address: _____

Emergency contact (not living with you): _____ Home phone:( ) _____

Relationship: _____ Work phone:( ) _____

IF THE PATIENT IS A CHILD OR FULL-TIME STUDENT, PLEASE COMPLETE

Mother's name: _____ SS#: ___ — ___ — _____ DOB: __/__/__
MM/DD/YY

Address (if different): _____ Home phone:( ) _____

Mother's employer's name: _____ Work phone:( ) _____

Mother's employer's address: _____

Father's name: _____ SS#: ___ — ___ — _____ DOB: __/__/__
MM/DD/YY

Address (if different): _____ Home phone:( ) _____

Father's employer's name: _____ Work phone:( ) _____

Father's employer's address: _____

MEDICAL INFORMATION

Primary care doctor: _____

Primary care doctor's address: _____

Patient name: _____ Account #: _____

HISTORY OF PRESENT ILLNESS

What problem(s) brought you in to the doctor today? *Check all that apply.*

	Date of onset	Right/ Left	Pain	Numb	Tingling	Stiff	Sore	Weak	Swelling	Frequency	Duration	Radiation
Head												
Neck												
Upper back												
Mid-back												
Lower back												
Shoulder												
Arm												
Forearm												
Wrist												
Hand												
Ribs												
Buttock												
Hip												
Thigh												
Leg												
Knee												
Ankle												
Foot												

Which is your chief concern? _____

How did you injure yourself? _____

How **severe** is the pain on a scale of 0 to 10 with 0 being none and 10 being the worst pain imaginable?

Circle one 0 1 2 3 4 5 6 7 8 9 10

Does anything make it better? _____

Does anything make it worse? _____

Have you been seen or treated for this problem before? ☐ Yes ☐ No

If yes, by whom? _____

What treatments have you had? ☐ None ☐ Medicine ☐ Physical therapy ☐ Surgery
☐ Other _____

Did any of these treatments help? ☐ Yes ☐ Yes, but it came back ☐ Partially
☐ No

Have you had anything like this in the past? ☐ Yes ☐ No ☐ Not sure

Other concerns: _____

_____

_____

_____

_____

Patient name: _____ Account #: _____

MEDICAL ILLNESSES

Do you have presently or have you ever been diagnosed with any of these diseases?

☐ Heart disease	☐ Stomach disorder	☐ Blood clots in legs	Others
☐ High blood pressure	☐ Back/disc problems	☐ Cancer	_____
☐ Stroke/TIA	☐ Neck problems	☐ Thyroid disease	_____
☐ Seizures	☐ Scoliosis	☐ Kidney disease	_____
☐ Leg swelling	☐ Pinched nerve in spine	☐ Liver disease	_____
☐ Asthma	☐ Migraine/headaches	☐ Depression	_____
☐ Joint swelling	☐ Arthritis	☐ Diabetes	_____

Please list and explain any SURGICAL OPERATIONS and approximate dates

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list and explain any HOSPITALIZATIONS and approximate dates

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list and explain any PAST TRAUMA and approximate dates

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list and explain any PAST CHIROPRACTIC CARE and approximate dates

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Immunization History (please record the year the vaccine was last given)

_____ Tetanus
_____ MMR
_____ Hepatitis A
_____ Hepatitis C
_____ Pneumovax (pneumonia vaccination)
_____ Influenza
_____ Hepatitis B

FAMILY HISTORY

Do any immediate family members (parents, siblings, or children) suffer from the following?

Disease	Family member
Back/Disc disease	
Neck problems/arthritis	
Osteoporosis	
Scoliosis	
Pinched nerve in spine	
Cancer	
Migraine/headache	
Osteoarthritis	
Rheumatoid arthritis	
Connective tissue disease	

Disease	Family member
Heart attack	
Coronary artery disease	
Congestive heart failure	
High blood pressure	
Stroke/CVA/TIA	
Peripheral artery disease	
Diabetes	
Kidney disease	
Thyroid disease	
Digestive disorder	

Patient name: _____ Account #: _____

MEDICATIONS

Prescription medications	Dosage (e.g. mg)	How often do you take it?	What is it for?

Over-the-counter medications	Dosage (e.g. mg)	How often do you take it?	What is it for?

Nutritional supplements	Dosage (e.g. mg)	How often do you take it?	What is it for?

ALLERGIES TO MEDICATIONS

Medication	Allergic reaction

☐ No known allergies to medications

SOCIAL HISTORY

Do you drink caffeine? ☐ No ☐ Yes If yes, how much?_____ How often?_____
Do you drink alcohol? ☐ No ☐ Yes If yes, how much?_____ How often?_____
Do you smoke? ☐ No ☐ Yes If yes, how much?_____ How often?_____
Do you exercise? ☐ No ☐ Yes If yes, how much?_____ How often?_____
Do you suffer from substance abuse? ☐ No ☐ Yes If yes, what substances?_____

What sports do you participate in? _____
What are your hobbies?_____

WORK HISTORY

What is your occupation? _____ ☐ Full-time ☐ Part-time
Does your present complaint affect the number of hours you work per day? ☐ No ☐ Yes
Job duties include:

☐ Lifting (_____ pounds) ☐ Bending ☐ Stooping
☐ Carrying ☐ Twisting ☐ Walking
☐ Turning ☐ Other:_____

What is your primary work position?

☐ Seated ☐ Counter ☐ Standing
☐ Desk ☐ Other:_____

What is your dominant hand? ☐ Right-handed ☐ Left-handed ☐ Ambidextrous
Which of the following best describes your stress level?

☐ None ☐ Minimal ☐ Moderate ☐ High

How do you rate your physical activity at work?

☐ Seated more than 50 percent of your day ☐ Light manual labor
☐ Moderate manual labor ☐ Heavy manual labor

ACTIVITIES

Which activities aggravate your condition?

☐ Vacuuming/cleaning ☐ Dishwashing ☐ Laundry
☐ Shopping ☐ Caring for family ☐ Carrying groceries/bags
☐ Grooming ☐ Bathing ☐ Dressing
☐ Eating ☐ Moving your bowels ☐ Reading
☐ Using the telephone ☐ Other:_____

Patient name: _____ Account #: _____

REVIEW OF SYSTEMS

Please check all that apply:

General
- ☐ Weight loss
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Fatigue

Eyes
- ☐ Double vision
- ☐ Eye redness
- ☐ Sensitivity to light
- ☐ Cataracts
- ☐ Dry eyes
- ☐ Eye pain
- ☐ Blurred vision

Ears, Nose, Mouth, Throat
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Ringing in your ears
- ☐ Spinning/dizziness
- ☐ Bloody nose
- ☐ Loss of smell
- ☐ Nasal congestion
- ☐ Sneezing
- ☐ Itchy nose
- ☐ Mouth pain
- ☐ Jaw pain
- ☐ Mouth sores
- ☐ Dry mouth
- ☐ Tongue changes
- ☐ Swollen throat
- ☐ Sore throat
- ☐ Throat pain
- ☐ Hoarseness

Cardiovascular
- ☐ Chest pain
- ☐ Ankle swelling
- ☐ Pain while walking
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Shortness of breath while lying down

Respiratory
- ☐ Wheezing
- ☐ Coughing blood
- ☐ Coughing
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Sputum

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Reflux
- ☐ Heartburn
- ☐ Indigestion
- ☐ Cramping
- ☐ Abdominal pain
- ☐ Black stools
- ☐ Passing of mucus
- ☐ Bloody stools
- ☐ Change of bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Anal pain/itching

Genitourinary
- ☐ Burning
- ☐ Increase frequency in urination
- ☐ Nighttime urination
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Frequent infections
- ☐ Impotence
- ☐ Genital soreness
- ☐ STD/VD
- ☐ Menstruation change

Musculoskeletal
- ☐ Muscle aches
- ☐ Joint aches
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Gout

Skin
- ☐ Rashes
- ☐ Skin itching
- ☐ Mole changes
- ☐ Dryness
- ☐ Hair changes
- ☐ Nail changes

Neurological
- ☐ Weakness
- ☐ Memory loss
- ☐ Loss of balance
- ☐ Seizures
- ☐ Confusion
- ☐ Tingling
- ☐ Numbness

Psychiatric
- ☐ Depression
- ☐ Insomnia
- ☐ Anxiety

Endocrine
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Weight gain
- ☐ Weight loss
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Neck swelling

Lymphatic, Blood
- ☐ Lymph node swelling
- ☐ Anemia
- ☐ Excessive bleeding
- ☐ Transfusions
- ☐ Bruise easily

Allergies
- ☐ Skin sensitivities
- ☐ Environmental allergies
- ☐ Frequent infections
- ☐ Food allergies

Patient name: _____ Account #: _____

FEMALE ONLY — PREGNANCY DISCLAIMER

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having x-rays taken at this time and grant permission for this procedure. In so doing, I release the doctor/clinic from responsibility for potential damage arising from this procedure. At the present time:

☐ I am sure that I am not pregnant. ☐ It is possible that I could be pregnant. ☐ I am pregnant.

_____ ____/____/____
Patient signature MM/DD/YY

_____ ____/____/____
Witness signature MM/DD/YY

PERSONAL INJURY

Is your condition due to:

Automobile accident? ☐ Yes ☐ No

Injury at work? ☐ Yes ☐ No

Date of injury: _____

INSURANCE INFORMATION

Primary insurance name: _____ Effective date: _____

Name of insured: _____ ID#: _____ Group #: _____

Insurance claim address: _____

City: _____ State: _____ ZIP: _____ Phone number: _____

Employer of insured: _____ DOB of insured: ____/____/____ MM/DD/YY

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary insurance name: _____ Effective date: _____

Name of insured: _____ ID#: _____ Group #: _____

Insurance claim address: _____

City: _____ State: _____ ZIP: _____ Phone number: _____

Employer of insured: _____ DOB of insured: ____/____/____ MM/DD/YY

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this 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 this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that should I personally receive an insurance check for services rendered at Midlands Health Center, I will bring the check and the accompanying explanation of benefits to the office so that it can be posted to my account. I am not an agent or representative of any insurance company or any other business trying to collect information. All injuries/problems mentioned are true and I am here solely for the treatment of said problems.

Patient name printed: _____

Patient signature: _____ Date: _____

Today I will be paying by (PLEASE CIRCLE ONE)

Cash Check Visa/MC/Discover