



healthcarecomplete

- Individualized Family Chiropractic Care
- Customized Nutritional Counseling
- Pediatric & Perinatal Certified
- Rehabilitative Exercise

PERSONAL HISTORY

Name: _____ Today's Date _____

Address: _____ Business Employer: _____

City: _____ Type of Work: _____

State: _____ Zip/Postal Code: _____ Work Phone: _____

Home Phone Number: _____ Cell: _____

Date of Birth: _____ Age: ___ Sex: M F Circle One: Single Married Widowed Divorced Separated

Email Address: _____ Name Of Spouse (If applicable): _____

Name of Individual you authorize us to share your health information/appointment scheduling/financial information: _____

Referred To This Office By: _____ Phone Number of Emergency Contact: _____

Who is Responsible For Your Bill, You and Spouse Workers' Comp Auto Insurance Medicare

Personal Health Insurance Co.: _____ Health Card Number: _____

Insured Person's Name: _____ Insured Person's Date of Birth: _____

Name of Primary Care Physician (PCP): _____

PCP Address: _____

CURRENT HEALTH CONDITION

Reason for Visit: _____

When Did This Condition Begin? _____ Has the Condition Occurred Before? Yes No

Is this condition getting worse? Yes No Rate the severity of the pain 1 (least pain) to 10 (severe pain) _____

Type of Pain: Sharp Dull Throbbing Numb Stiff Burning Aching Shooting Tingling Cramping _____

How often do you have this condition: _____ Does it interfere with: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Lifting Walking Lying Down

Other Doctors Seen For This Condition: Yes No If Yes Who? _____

Type of Treatment: _____ Results: _____

Is Condition: Job Related Auto Accident Home Injury Fall Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made A Report Of Your Accident To Your Employer/Insurance Company: Yes No

Drugs You Take Now: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine Insulin Other

Vitamins/Herbs/Minerals You are taking: _____

Do You Suffer From Any Other Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery Broken Bones

Other (please list details) _____

Major Accidents Or Falls: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit: _____

Date of Last: Spinal X-ray _____ MRI _____ (region: _____) Physical Exam _____

Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect you overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES or SYMPTOMS YOU HAVE HAD:

- | | | |
|--|---|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer (type: _____) | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |

Have you tested HIV Positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness
- Gas/Bloating After Meals
- Heartburn/Reflux
- Black/Bloody Stool
- Irritable Bowel/Colitis/Chron's

NERVOUS SYSTEM

- Weakness in arms/legs/body
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Cold or discolored extremities
- Fainting
- Convulsions or Seizures
- Tingling Extremities

GENERAL CODE

- Fatigue
- Allergies (List: _____)
- Loss of Sleep
- Fever
- Headaches

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine
- Kidney Stones

C-V-R

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems or congenital defect
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches or Infection
- Hearing Difficulty
- Stuffed Nose or Sinus Infection
- Ringing in the ears

MALE/FEMALE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems

FEMALES ONLY

When was your last period?

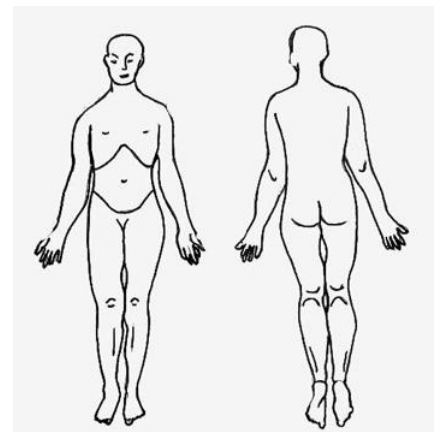
Are you Pregnant?

Yes No

MENTAL/EMOTIONAL

- Anxiety
- Psychotic episodes
- Attempted suicide in lifetime
- Anger/aggression
- Attention Deficit
- Depression

Please outline on the diagram the area of your discomfort



PAST HEALTH HISTORY (cont)

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

FAMILY HISTORY

List family members with the following illnesses:

- Heart Disease _____
- Cancer _____
- Diabetes _____
- Stroke _____
- Neurological Disorder _____
- Other _____

Height _____

Weight _____

EXERCISE

- None
- Mild 1-2x/wk
- Moderate 3x/wk
- Daily
- Heavy (daily and intense)

HABITS

- Smoking (Pack/day) _____
- Alcohol (Drinks/wk) _____
- Coffee/Caffeine (Cups/day) _____
- Water Ounces/day _____
- High Stress Level
Reason _____
- Things you do to handle stress

“GEORGE’S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST”

Instructions: Please check the correct response.

Historical Information

- Have you ever been diagnosed or told you have any of the following?
 1. High Blood Pressure (hypertension) Yes No
 2. Hardening of the arteries (arteriosclerosis) Yes No
 3. Diabetes Yes No
 4. Heart or blood vessel diseases Yes No
 5. Bone spurs on the neck bones (cervical spondylosis) Yes No
 6. Whiplash injury (flexion-extension injury) (cervical spine) Yes No
 7. Have any of your relatives suffered a stroke? Yes No
 8. Were you ever a smoker? If yes, from _____ to _____ Yes No
 9. Do you take any medications on a regular basis? Yes No
 - If yes, what? (Coumadin, Heparin, Aspirin, Anti-hypertensive medicine, etc.) _____
 10. (Women Only) Have you ever taken oral Contraceptives? Yes No
 - If yes, from _____ to _____
- Have you ever had any of the following, even short, temporary attacks, in the last year?
 1. Blurred Vision Yes No
 2. Double Vision Yes No
 3. Diminished or partial loss of vision in one or both eyes? Yes No
 4. Complete loss of vision in one or both eyes? Yes No
 5. Ringing, buzzing or any noise in the ear(s)? Yes No
 6. Hearing loss in one or both ears? Yes No
 7. Slurred speech or other speech problems? Yes No
 8. Difficulty swallowing? Yes No
 9. Dizziness? Yes No
 10. Temporary lack of understanding? Yes No
 11. Loss on consciousness, even momentary blackouts? Yes No
 12. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body? Yes No
 13. Any other abnormal sensations in any part of your body? Yes No
 14. Weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs? Yes No
 15. Sudden collapse without loss of consciousness? Yes No

healthcarecomplete

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978-499-WELL (9355)

Release of Patient Information

Patient Name (print) _____ **Date of Birth:** _____

Authorized Release of Records to Primary Care Physician

I hereby authorize Healthcare Complete to release health care information regarding my treatment to the PCP listed below. I understand that records may be released while I am under care per my request to my PCP.

Primary Care Provider Information

Doctor Name/Practice Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Patient Signature _____

Authorized Release of Medical Records from other Providers

I hereby authorize Healthcare Complete to obtain any of the following medical records from my previous or concurrent medical providers: X-ray, MRI, CT films and reports, SOAP notes, prescriptions, lab tests and any other necessary medical records.

I hereby authorize the following medical facilities to release medical information pertinent to the management of my health.

Doctor Name/Facility Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Patient Signature _____

CREDIT CARD PREAUTHORIZATION

Healthcare Complete
260 Merrimac Street-The Towle Building
Newburyport, MA 01950
978-499-WELL (9355)

To better serve our patients, and to give the best care to everyone, we are requiring a credit/debit card to be kept confidentially in each individual's file. Please complete the information below:

Patient Name: _____

I authorize Healthcare Complete to charge my credit card account for patient care under the following circumstances (check off each one that you authorize):

- Please charge my credit card weekly in pre-payment of my appointments
- Please charge my credit card after each visit
- My bill is over 90 days past due, and an attempt to reach me by phone or mail has been made, without response.
- My insurance didn't cover a service I received, and an attempt to reach me by phone or mail has been made, without response.

Circle one: MasterCard Visa Other _____

Charge Account Number: _____ Exp. Date _____

Cardholder Name: _____

I understand that this form is valid for one year unless I cancel the authorization with written notice to Healthcare Complete.

Cardholder Signature _____ Date _____