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 Phone:_____Carrier_____

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

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

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

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

_____

Vitamins/Herbs/Minerals You are taking: _____

_____

PAST HEALTH HISTORY

Please Check all that apply and write dates:

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:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer (type: _____)
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ 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?

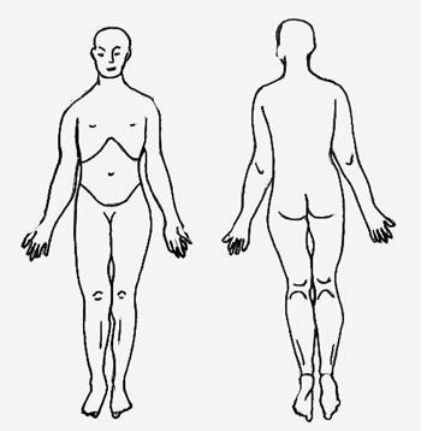
_____

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. (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

For Electronic Health Records:

☐ I choose to decline receipt of my clinical summary after every visit
(These summaries are often blank as a result of the nature and frequency of care)

healthcarecomplete

Dr. Jennah Dieter, D.C., C.A.C.C.P.
260 Merrimac St.
Newburyport, MA 01950
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 require a credit/debit card to be kept confidentially in each patient 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.

Cardholder Signature:_____Date_____