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: ____

Medications 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?

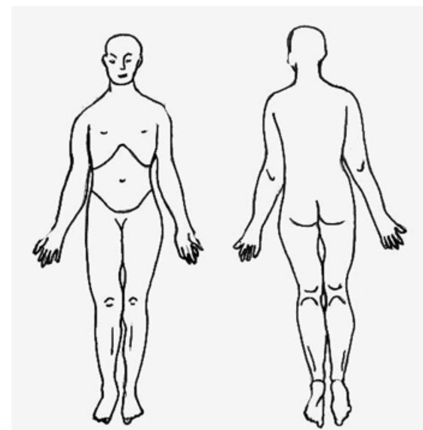
____

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____________________