

Chiropractic Case History/Patient Information

Date: _____ Patient # _____ Doctor: _____

Name: _____ Social Security # _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Fax # _____ Cell Phone: _____

Age: _____ Birth Date: _____ Race: _____ Marital: M S W D Gender: M F

Occupation: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse: _____ Birth Date: _____ Employer: _____

How many children? _____ Names and Ages of Children: _____

Name of Nearest Relative: _____ Address: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____

May we have your permission to update your medical doctor regarding your care at this office? _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____ Is this due to: Auto ___ Work ___ Other _____

Have you ever had the same or a similar condition? Yes No If yes, when and describe: _____

Days lost from work: _____ Date of last physical examination: _____

Have you ever seen a chiropractor before? _____ If yes, Name of Dr.: _____

Location: _____ Date of last visit: _____ (approx)

PAST MEDICAL HISTORY

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about

childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, please describe: _____

SOCIAL HISTORY:

Do you drink alcoholic beverages? ___ If so, how much per week? _____

Do you use any tobacco products? ___ Do you smoke? ___ If so, packs per day: _____

Do you consume caffeine? ___ If so, how much per day: _____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

lifting ___ sitting ___ bending ___ working at a computer _____

Please circle any and all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

PERSONAL INJURY QUESTIONNAIRE

NAME: _____ Date of Accident _____

Where did accident happen? Describe the accident in your own words:

What was your position in the car?

Driver: if Driver were your hands on the steering wheel? Left Right Both

Passenger: If passenger, were you sitting in Front Right Rear Left Rear

Did your vehicle strike another vehicle Yes No

Was your vehicle struck by another vehicle Yes No

Angles of impact... First Collision: Front Back Left Right

If Second Collision: Front Back Left Right

Were you wearing a seat belt? Yes No

Did you brace for impact? Yes No ... I braced with my hands I braced with my feet

Which way were you facing at the time of impact... straight ahead Left Right

Did you strike anything in vehicle at time of impact? Yes No

If yes, specify what part of your body struck what: ie... head chest chin shoulder Right / Left Knee

Steering Wheel _____ Dashboard _____

Windshield _____ Roof _____

Left Side Door _____ Right Side Door _____

Left Side Window. _____ Right Window _____

Other _____

Did the seat back bend / break ? Yes No

Immediately following the accident, how did you feel? dizzy/dazed disoriented unconscious

nervous nauseous upset weak Other _____

Did you go to hospital Yes No Were you admitted to the hospital? Yes No if yes how long? _____

If you went to hospital, when? At time of accident Next day

How did you get to hospital? Ambulance Police Car Private Transportation

Name of Hospital: _____

Attended by Dr. _____

... what treatment was given?

none placed in a cervical collar x-rayed given stitches Bandaged

given pain medication given instructions regarding concussions

given instructions regarding sprains and strains Physical Therapy

instructed to call a Orthopedic Surgeon instructed to call a private physician

referred to this office for treatment Other _____

Have you seen any other doctor as a result of this accident? Yes No

Doctor's name

CHIEF Complaints or Symptoms:

Name:

Date:

<input type="checkbox"/> Neck pain check off the areas that the pain runs into from the neck	<input type="checkbox"/> none	<input type="checkbox"/> left shoulder	<input type="checkbox"/> left arm	<input type="checkbox"/> left forearm	<input type="checkbox"/> left hand
	<input type="checkbox"/> right shoulder	<input type="checkbox"/> right arm	<input type="checkbox"/> right forearm	<input type="checkbox"/> right hand	
<input type="checkbox"/> headache					
<input type="checkbox"/> Migraine Headache					
<input type="checkbox"/> upper back pain					

Ringing in Ears Yes No Left Right Both Ears

Blurry Vision Yes No Left Right Both Eyes

Wrist Pain Yes No Left Right Both Wrists

Jaw Pain Yes No Left Right Both Sides

Dizziness nervousness fatigue anxiety depression excessive irritability
 fear of driving in a car a loss of concentration jaw clenching grinding of teeth at night
 nightmares difficulty with sleeping at night

<input type="checkbox"/> Low Back Pain select the areas of radiation, if any...	<input type="checkbox"/> none	<input type="checkbox"/> buttocks	<input type="checkbox"/> left buttock	<input type="checkbox"/> left thigh	<input type="checkbox"/> left knee
	<input type="checkbox"/> left foot	<input type="checkbox"/> right buttock	<input type="checkbox"/> right thigh	<input type="checkbox"/> right knee	<input type="checkbox"/> right foot

Hip Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral
Knee Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral
Foot Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral

Numbness:

Left Hand Left Upper Arm Right Hand Right Upper Arm
 Left Foot Left Leg Right Foot Right Leg

Additional Symptoms/ Complaints:

Have You lost any time from work due to your injuries? Yes No

If yes please give dates: _____

Type of employment: _____

Have you had previous injuries or accidents? Yes No

Description of previous Accident: _____

Description of previous injuries: _____

Is there any residual pain from the previous injury? Yes No

How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____

Patient Health Questionnaire - PHQ

Form PHQ-202

rev 7/18/05

Patient Name _____ Date _____

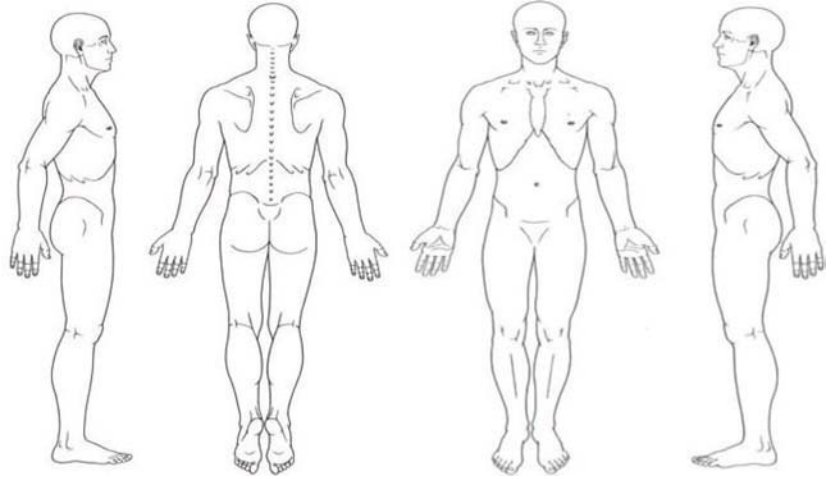
1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all
- ② A little bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

- ① All of the time
- ② Most of the time
- ③ Some of the time
- ④ A little of the time
- ⑤ None of the time

7. In general would you say your overall health right now is...

- ① Excellent
- ② Very Good
- ③ Good
- ④ Fair
- ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____ Date _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓟ The pain comes and goes and is very severe.
- Ⓡ The pain is very severe and does not vary much.

Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓟ Because of pain my normal sleep is reduced by less than 75%.
- Ⓡ Pain prevents me from sleeping at all.

Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓜ Pain prevents me from sitting more than 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- Ⓟ Pain prevents me from sitting more than 10 minutes.
- Ⓡ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓨ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓟ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓡ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓟ I cannot walk more than 1/4 mile without increasing pain.
- Ⓡ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓟ Because of the pain I am unable to do some washing and dressing without help.
- Ⓡ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓟ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓡ I can only lift very light weights.

Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓟ Pain restricts all forms of travel except that done while lying down.
- Ⓡ Pain restricts all forms of travel.

Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓟ Pain has restricted my social life to my home.
- Ⓡ I have hardly any social life because of the pain.

Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓟ My pain is gradually worsening.
- Ⓡ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back
Index
Score

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Sleeping

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Work

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck
Index
Score

Patient Health Questionnaire – Page 2

Patient Name: _____ Date: _____

What type of regular exercise do you perform? None Light Moderate Strenuous

What is your height and weight? Height _____ ft. _____ in. Weight _____ lbs.

For each of the conditions listed below, place a check in the past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the present column.

<input type="radio"/> Past	<input type="radio"/> Present	<input type="radio"/> Headaches	<input type="radio"/> Past	<input type="radio"/> Present	<input type="radio"/> High Blood Pressure	<input type="radio"/> Past	<input type="radio"/> Present	<input type="radio"/> Diabetes
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Neck Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Heart Attack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Excessive Thirst
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Upper Back Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Chest Pains	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Freq. Urination
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Mid Back Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Ruptures
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Low Back Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Angina	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Coughing Blood
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Shoulder Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Kidney Stones	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Eating Disorder
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Elbow/Upper Arm Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Kidney Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Pace Maker
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Wrist Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Bladder Infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Allergies
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Hand Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Painful Urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Depression
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Hip/Upper Leg Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Loss of Bladder Control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Systemic Lupus
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Knee/Lower Leg Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Prostate Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Epilepsy
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Ankle/Foot Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Abnormal Weight Gain/Loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Dermatitis/Rash
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Jaw Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Loss of Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> HIV/AIDS
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Joint Swelling/Stiffness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Abdominal Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> High/Low B.P.
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Ulcer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Osteoarthritis
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Hepatitis	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> General Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Liver/Gall Bladder Disorder	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Muscular Incoordination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Cancer	<input type="radio"/>	<input type="radio"/>	Females Only
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Visual Disturbances	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Tumor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Birth Control
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Hormonal Rep.
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Numbness/Tingling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Chronic Sinusitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Pregnancy
<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Smoking/Use Tobacco Prod.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Broken/Fractured Bones	<input type="radio"/>	<input type="radio"/>	
			<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Circulatory Problems	<input type="radio"/>	<input type="radio"/>	Other Health Problems
			<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Seizures/Convulsions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
			<input type="radio"/>	<input type="radio"/>	<input type="radio"/> A Congenital Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
			<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Excessive Bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
			<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Drug/Alcohol Dependence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you have any allergies to any medications? Yes No
If yes, describe: _____

Do you have allergies of any kind? Yes No
If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be: _____

Family Diseases (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

___ Tuberculosis ___ Cancer ___ Mental Illness ___ Diabetes ___ Asthma
___ Stroke ___ Kidney Disease ___ Lung Disease ___ Arthritis ___ Liver Disease
___ Heart Disease ___ Other: _____

List all prescription, over-the-counter medications, and nutritional/herbal supplements you are taking:

List all the surgical procedures you have had and times you have been hospitalized: _____

Patient's Signature: _____ **Doctor's Signature:** _____