Civano Chiropractic, LLC

PATIENT INFORMATION (please print)

Last Name___________________________________ First______________________________ MI_____

Nickname______________________ Address ____

City ____________________________State ________Zip __________Home Ph: __________________

Office Ph: _________________ Cell Ph: ________________ E-mail: ___________________________

Age ____ Date of Birth _____________ Sex **M** **F**

Referred by ____

Occupation________________________________Employer____________________________________

Address __________________________________ Primary Care Physician_______________________

Married ___ S ___ W ___ D ___ Children _____ Spouse's Name __________________________

HEALTH HISTORY INFORMATION (circle yes or no)

Is any other member of your family being treated in this office? ___________________________________

Have you ever had chiropractic care before? **Yes** **No** Were results satisfactory? **Yes** **No**

For what problem? ____

Major complaints and symptoms — please be as specific as you can. ___________________________

____

How do you believe your problem (pain) began? ____

____

When did you first notice this problem/pain? ____

Have you lost any work? **Yes** **No** Day and date you last worked ____________________________

Have you ever had this condition before or a similar condition? **Yes** **No** When? ________________

What positions or activities aggravate your condition? ______________________________________

What positions or activities relieve your condition? ____

Have you ever been treated by a Medical Provider for this ailment? **Yes** **No** Who/where?
____ Provider's Diagnosis ___________________________

Describe the type of treatment ____

Length of time under care____________________ Results ___________________________________

Have you ever been in **any accidents** i.e. auto, fall down stairs, fall from ladder, etc. (even as a child)?
Yes **No** If yes, what and when? ____

Are you allergic to anything you are aware of? **Yes** **No** Substance? ___________________________

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Are you presently taking any medication, herbs, supplements or over the counter products (aspirin included)? **Yes** **No** If yes, name them ____

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Have you ever broken any bones? (Fractures) __________________ Any dislocations? _______________

Patient Signature____ **Date**____________________________

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Tucson, AZ 85747

Civano Chiropractic, LLC

What operations have you had? 1) ___________________Year ________ 2) _________________Year ______
3) ___________________Year _______ 4) __________________Year ________

Have you ever had any cosmetic surgery, breast implants, etc.? **Yes** **No**

Body area? 1) ___________________Year ________ 2) ___________________Year ________

Have you had any surgery to replace hip, knee, etc.? **Yes** **No**

Body area? 1) ___________________Year ________ 2) ___________________Year ________

If you have had any of the following procedures, please give **date**, treating **doctor**, and treating **facility** (if exact date is unknown, give approximate):

Blood tests ____ Urinalysis ______________________________________

X-Ray examination __________________________________ Ultrasound __________________________________

MRI ____ CT Scan ____

Radiation Treatment __________________________ Other special treatment ____________________________

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

If yes, what condition? ____

Do you have any health problems not listed above? ____

Date of last menstrual period ______________________

Do you have any reason to believe that you may be pregnant? **Yes** **No**

Do you faint easily? **Yes** **No** Have you been diagnosed with hypertension? **Yes** **No**

Do you take vitamins? **Yes** **No** If yes, please list them ____

Do you exercise regularly? **Yes** **No** What kind of exercise? __________________________________

Have you lost or gained weight in the past year? **Yes** **No** Amount_________________

Habits: (please check)

Cigarettes? **Yes** **No** Packs ______per day Coffee? **Yes** **No** Cups ______per day

Alcohol? **Yes** **No** Drinks ______per day/week Tea? **Yes** **No** Cups ______per day

Hobbies? ____

Use this space for any additional information you may wish to discuss.

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ACCEPTANCE AS PATIENT

I understand and agree that the doctors of Civano Chiropractic, LLC have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Patient Signature____ **Date**___________________________

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