Calloway Chiropractic Clinic

NAME:_____Phone: (H):_____ (C):_____ (W):_____

Would you prefer phone or text message reminders? Circle the best number. Email: _____

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

Age :_____ Sex (F/M): ____ Date of Birth: _____ Marital Status: _____ Children(#): _____

Occupation: _____ Employer: _____

Spouse's Name: _____ Referred By: _____

Emergency Contact: _____ Phone: _____

Date of last physical exam:_____ With Whom?:_____ Where: _____

Reported Findings :_____

Have you been treated for any health condition in the last year? _____ If yes, by whom? _____

Describe: _____

Purpose of this appointment: _____

How will you know that you are better:_____

Additional Information or Remarks: _____

Patient Agreement

I understand and agree that non-Medicare health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I agree to file my non-Medicare insurance claims myself. I understand that if I am eligible for Medicare or Medicaid, the clinic does not file Medicare or Medicaid claims. I also understand that Medicare and Medicaid do not cover services rendered from this clinic.
I declare that I am personally responsible for the payment of Calloway Chiropractic Clinic services, when these services are rendered. For missed appointments, if I fail to give twenty-four hour advance notice of cancellation, then I will be charged a $50 fee for late cancellation.

Patient's signature:_____ **Date:** _____

Guardian/parent signature authorizing care: _____ Date: _____

Surgeries, Hospitalizations, Serious Illnesses (List the date in brackets): _____

Fractures, Dislocations, Motor Vehicle Accidents, Major falls or head injuries (List year in brackets): _____

Current medications you are taking: _____

Please check all conditions that you have ever had:

__ Allergies/Hayfever	__ Alcoholism/Addiction	__ Anemia	__ Anxiety	__ Arthritis/Joint Pain
__ Asthma	__ Autoimmune Disease	__ Cancer	__ Depression	__ Diabetes
__ Digestive Disorders	__ Dizziness/Vertigo	__ Epilepsy	__ Fatigue	__ Headache/Migraine
__ Heart Trouble	__ High Blood Pressure	__ Neck Pain	__ Hypoglycemia	__ Neuritis
__ Numbness	__ Poor Appetite	__ Parasites	__ Poor Circulation	__ Prostrate Problems
__ Rheumatic Fever	__ Sinus Trouble	__ Stroke	__ Tuberculosis	__ Ulcers
__ Urinary Trouble, UTIs	__ Venereal Disease	__ Lymes	__ Weight Loss	__ Yeast/Candida

Height:____ Weight now: _____ Weight 1 Yr. ago: _____ Adult Max: _____ Adult Min: _____

Known Allergies: _____

Have you ever had a blood transfusion? Yes/No

Do you smoke? Y/N What?_____ How many/day? _____ Since when? _____

Other tobacco products? Y/N What?_____ How many/day? _____ Since when? _____

Drink coffee? Y/N Cups/day:_____ Drink caffeinated tea: Y/N Cups/day: _____

Colas/Soft drinks Y/N Number/day_____ Glasses of water/day: _____

Alcoholic Beverages Y/N Avg. #/week_____ What type: _____

Are you avoiding any foods? Y/N If so what?: _____ Are you a vegetarian:_____

Are you vegan? Y/N Bowel Movement frequency: _____Difficulty? Y/N

Approximate number of times you urinate per day: _____ Do you sleep well? Y/N If no, describe:_____

Average number of hours/night: _____ Do you have enough energy for normal activities Y/N

If no, describe: _____

Do you wear corrective lenses? Y/N Has your vision changed recently? Y/N Explain: _____

Do you wear heel lifts or supports? Y/N Explain: _____

List any nutritional supplements that you take: _____

X-RAY HISTORY: (Include CAT, MRI, dye studies and dental) When was most recent x-ray/other study?_____

Age	Body Area	Type (Normal X-ray, CAT, MRI, etc.)	Number of Studies

FAMILY HISTORY

	Living	Age or Age at Death	Allergies	Arthritis	Alcoholism or Addiction	Autoimmune Disease	Cancer	Depression	Diabetes	Heart Disease	High Blood Pressure	Stroke	Digestive Issues	Other, Description
Father														
Dad's Mom														
Dad's Dad														
Dad's Siblings														
Mother														
Mom's Mom														
Mom's Dad														
Mom's Siblings														
Your Siblings														
Your Children														

WOMEN ONLY: Menstrual History

Age at Onset: _____ Are your periods regular? Y/N Days of Cycle: _____ Use Birth Control Pill? Y/N

IUD or other? Y/N Your flow is: heavy medium light Cramping? Y/N PMS? Y/N If so, what: _____

Other Menstrual/Hormonal Symptoms: _____