Confidential Patient History for:

# *College Place Chiropractic*

**Dr. Derek R. Hayden and Dr. Teresa Miller Hayden**
**716 S. College Ave.**
**College Place, WA 99324**

Name: _____ Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: _____

SSN: _____ Marital Status: _____ E-mail Address: _____

Employer: _____ Type of Work: _____

Names and Ages of Children: _____

Referred To This Office By: _____

Name/Number/Relationship of Emergency Contact: _____

Who Is responsible For Your Bill (circle one): Self L&I Auto Insurance Medicare Other

Please Present Your Insurance Card

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Why Chiropractic? People go to Doctors of Chiropractic for a variety of reasons. Some go for relief of pain (Relief Care). Others are interested in having the cause of their problems as well as their symptoms corrected (Corrective Care). Still others wish to have routine care in order to maintain their current level of health (Maintenance Care). Please check the type of care you desire so that we may be guided by your wishes.

_____ **Relief Care** _____ **Corrective Care** _____ **Maintenance Care**

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid to the Doctor's office will be credited to my account on receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I terminate my care, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he/she deems appropriate. It is understood and agreed the amount paid for x-rays is for examination only and the negatives will remain the property of this office, where they will remain on file. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature: _____ Date: _____

Guardian (when applicable): _____

## CURRENT HEALTH CONDITION

Describe unwanted health condition: _____

How long have you had this condition? _____ Is it getting worse? _____

What makes it better/worse? _____

Initial cause of condition: _____

List any accidents/falls: _____

List any surgeries: _____

List any medications you are presently taking: _____

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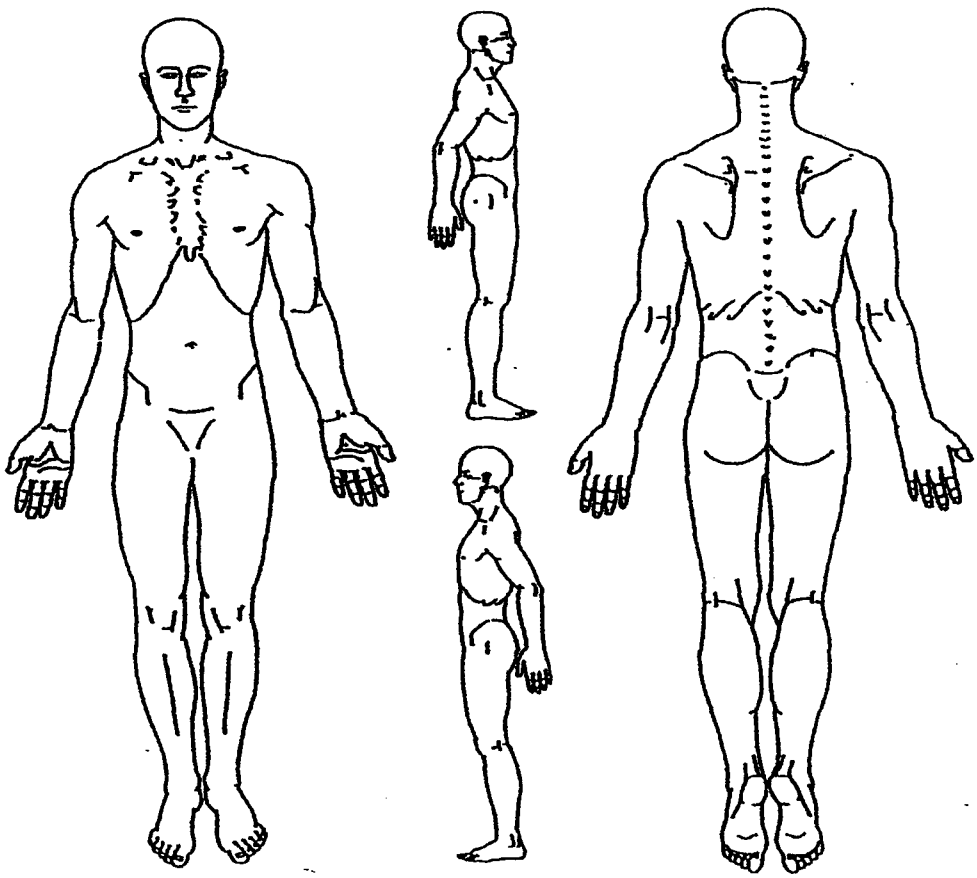
ON THE DIAGRAMS BELOW, PLEASE MARK WHERE YOU ARE EXPERIENCING PAIN, RIGHT NOW. USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS.

| KEY: | A-ACHE | B-BURNING | N-NUMBNESS |
|---|---|---|---|
| | P-PINS & NEEDLES | S-STABBING | O-OTHER |



**PAIN SCALE:**
Rate the severity of your pain by checking one box on the following scale.

| NO PAIN | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | EXCRUCIATING PAIN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

NAME: _____ AGE: ____ BIRTH DATE: _____ TODAYS DATE: _____

Please enter: **"1" (mild), "2" (moderate), "3" (severe),** in front of all of the following symptoms.

leave blank if it does not pertain to you...

**GENERAL SYMPTOMS**

___784.0 headache
___780.6 fever
___780.9 chills
___780.8 night sweats
___780.2 fainting
___780.4 dizziness
___780.3 convulsions
___780.52 loss of sleep
___780.7 fatigue
___799.2 nervousness
___783 loss of weight
___782 pain or numbness in extremities
___995.3 allergy (what)
___786.09 wheezing
___729.2 neuralgia

**MUSCLES AND JOINTS**

___ weakness
___ twitching
___847 stiff neck
___722.10 backache
___719 swollen joints
___781 tremors
___729.5 foot trouble
___724.79 painful tail bone
___724.5 pain between shoulders
___563.6 hernia [disc]
___737.3 spinal curvature
___ Spinal surgery

**OTHER [ PLEASE LIST]:**

**GASTRO-INTESTINAL**

___783 poor appetite
___536.8 poor digestion
___994.2 excessive hunger
___787.3 belching or gas
___787 nausea
___787 vomiting
___578 vomiting blood
___536.8 pain over stomach
___564 constipation
___558.9 diarrhea
___789 colon trouble
___455.6 Hemorrhoids
___785.1 liver trouble
___782.4 jaundice
___575.9 gall bladder trouble

**VASCULAR**

___783 rapid heart
___427.89 slow heart
___401.9 high blood pressure
___458.9 low blood pressure
___ pain over heart
___ heart trouble
___719.07 swollen ankles
___759.9 poor circulation
___ varicose veins
___436 strokes

[ _____ ] Cancer
Type I / Type II Diabetes

**EYES / EARS / NOSE / THROAT**

___368.9 poor vision
___378.9 crossed eyes
___379.91 pain in eyes
___389.9 deafness
___388.70 earache
___388.30 ear noises
___388.60 ear discharges
___478.1 nasal obstruction
___784.7 nose bleeds
___462 sore throats
___477.9 hay fever
___493.9 asthma
___460 frequent colds
___240.9 enlarged thyroid
___463 tonsillitis
___686.9 sinus trouble
___ Glaucoma

**SKIN OR ALLERGIES**

___368.9 skin eruptions
___698.9 itching
___278.8 bruising easily
___701.1 dryness
___ boils
___782 sensitive skin
___708.9 hives or allergy
___692.9 eczema
___ medicines
yes no HIV positive
yes no Hepatitis [ ]

**RESPIRATORY**

___786.2 chronic cough
___786.3 spitting blood
___933.1 spitting phlegm
___786.50 chest pain
___786.09 difficulty breathing

**GENITO-URINARY**

___788.3 frequent urination
___788.1 painful urination
___599.1 blood in urine
___591 kidney infection
___783.3 bed wetting
___788.1 inability to control urine

**FOR MEN ONLY**

___601.9 prostate problem

**FOR WOMEN ONLY**

___786.2 painful periods
___626.2 excessive flow
___626.4 irregular cycle
___627.2 hot flashes
___625.3 cramps or backaches
___634.9 miscarriage
___623.5 vaginal discharge
[ _____ ] surgery
___ Endometriosis
___yes no currently pregnant
Last period start date:

Rate the level of stress in your life: _____

The following members of my family have a 'same or similar' problem as I do:

❑ Mother ❑ Father ❑ Brother ❑ Sister ❑ Spouse ❑ Child:

❑ "I am adopted - not sure of family health history"

❑

❑

➡ [please circle symptoms / conditions above other family members have]

Signature: _____ Date: _____

Guardian / Spouse: _____ Date: _____

Please proceed to completing the other forms provided before seeing the doctor.