PEAK
HEALTH CENTER

PLEASE NOTE:

This file must be saved to your desktop before and after completing!

PATIENT INFORMATION

Date _____ First Name _____ Middle Name _____ Last Name _____

SSN _____ Sex _____ Birth Date _____ Height _____ Weight _____

Marital Status _____ Spouse Name _____ Number of Children _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Emergency Contact _____

Emergency Relation _____ Emergency Phone _____

REFERRAL INFORMATION

I was referred by _____

How did you hear about the clinic?

☐ Advertisement ☐ Newspaper ☐ Community Event ☐ Provider Talk ☐ Family/Friend ☐ Other _____

INSURANCE INFORMATION

Primary Insurance Information

Insurance Company Name _____ Plan Name _____

Phone # _____ Primary ID/Policy _____ Primary Group # _____

Policy Holder's Name _____ Policy Holder's DOB _____

If you are NOT the Policy Holder, what is your relation to the Policy Holder? _____

For verification puposes, what is the Policy Holder's Social Security Number? _____

Secondary Insurance Information

Insurance Company Name _____ Plan Name _____

Phone # _____ Secondary ID/Policy _____ Secondary Group # _____

Policy Holder's Name _____ Policy Holder's DOB _____

If you are NOT the Policy Holder, what is your relation to the Policy Holder? _____

For verification puposes, what is the Policy Holder's Social Security Number? _____

EMPLOYER INFORMATION

Employed? ☐ Yes ○ No Employer Name _____

Occupation _____

REASON FOR VISIT

Describe in your own words why you wanted to come for an appointment today:

PERSONAL HEALTH INFORMATION

Complaints/Concerns

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
E.g. Headaches	*June 2007*	*4 times per week*	*Mild / Moderate / Severe*
1.			
2.			
3.			
4.			
5.			
6.			
7.			

When was the last time you felt well? _____

Did something trigger your health changes?

Sleep

Average number of hours you sleep? _____ Do you have trouble falling asleep? ○ Yes ○ No

Do you feel rested upon awakening? ○ Yes ○ No Do you have problems with insomnia? ○ Yes ○ No

Do you snore? ○ Yes ○ No Do you use sleeping aids? ○ Yes ○ No Explain: _____

Injuries

Describe your injury and pain:

Pain level on scale of 1 - 10 (10 is excruciating pain) At its best? _____ At its worst? _____ Now? _____

Type of injury _____

How did it occur? ☐ Work ☐ Automobile ☐ Fall ☐ Other _____

Injury Date _____ Have you missed work related to this injury? ◯ Yes ◯ No

Unable to work from (dates) _____ to _____

Received other treatment for this? ◯ Yes ◯ No Where or by whom? _____

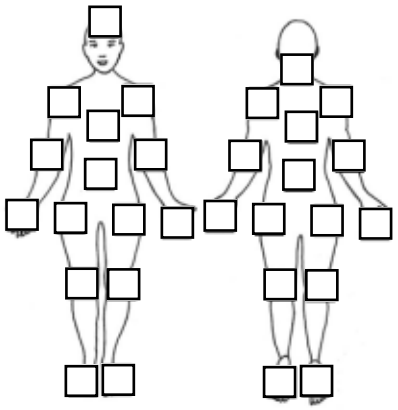
X-rays taken? ◯ Yes ◯ No Do you currently receive chiropractic care? ◯ Yes ◯ No

What clinic or chiropractor provides that care? _____

Please check the character of your current pain (you may check more than one):

Sharp ☐ Stabbing ☐ Dull ☐ Aching ☐ Soreness ☐ Stiffness ☐ Weakness ☐

Throbbing ☐ Numbness ☐ Shooting ☐ Burning ☐ Tingling ☐



Please rate the degree of you pain between 0-10, 0 being no pain and 10 being unbearable: _____

How often are your symptoms present?

Constant ☐ Frequent ☐ Occasional ☐ Intermittent ☐

Since your problem began, is the pain? Increasing ☐ Decreasing ☐ No Change ☐

What activities make symptoms BETTER? Sitting ☐ Standing ☐ Laying Down ☐

Movement/Exercise ☐ Sleep/Rest ☐ Other(describe) _____

What activities make symptoms WORSE? Sitting ☐ Standing ☐ Coughing/Sneezing ☐

Movement/Exercise ☐ Sleep/Rest ☐ Other(describe) _____

Tobacco/Alcohol

Currently using tobacco? ◯ Yes ◯ No How many years? _____ Packs per day _____

If yes, what type? ☐ Cigarette ☐ Smokeless ☐ Cigar ☐ Pipe ☐ Patch/Gum

Previous smoking? How many years? _____ Packs per day _____ Are you exposed to 2nd hand smoke? ◯ Yes ◯ No

If yes, explain: _____

How many drinks currently per week? (1 drink=5 oz. wine, 12 oz. beer, and/or 1.5 oz. spirits)

☐ None ☐ 1 to 3 ☐ 4 to 6 ☐ 7 to 10 ☐ More than 10

Previous alcohol intake? ◯ Yes ◯ No If yes, was it: ◯ Mild ◯ Moderate ◯ High

Allergies

I am allergic to the following medications:

I am allergic to the following foods or supplements:

Please list your symptoms/reactions to the above medications and/or foods:

Medications and Supplements

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.

Medication Name	Dosage

Supplements: List all vitamins, minerals, and other nutritional supplements that you are currently taking.

Supplement Name	Dosage

Health History

Have you ever had any of the following:

Illnesses	Yes	No
Chicken Pox	○	○
Measles	○	○
Mumps	○	○
Anemia	○	○
Arthritis	○	○
Asthma	○	○
Bronchitis	○	○
Cancer	○	○
Chronic Fatigue Syndrome	○	○
Crohn's Disease or Ulcerative Colitis	○	○
Diabetes	○	○
Emphysema	○	○
Epilepsy, convulsions	○	○
Gallstones	○	○
Gout	○	○
Heart attack/Angina	○	○
Heart failure	○	○
Hepatitis	○	○
High Blood Pressure	○	○
Irritable bowel	○	○
Kidney stones	○	○
Mononucleosis	○	○
Pneumonia	○	○
Rheumatic fever	○	○
Sinusitis	○	○
Sleep Apnea	○	○
Stroke	○	○
Thyroid disease	○	○
Other (describe)		

Injuries	Yes	No
Head Injury	○	○
Neck Injury	○	○
Back Injury	○	○
Fracture	○	○
Other (describe)		

Diagnostic Studies	Yes	No	Date Performed
Chest X-ray	○	○	
Mammogram	○	○	
EKG	○	○	
Colonoscopy	○	○	
Upper GI Series	○	○	
Barium Enema	○	○	
CAT scan of abdomen	○	○	
CAT scan of brain	○	○	
CAT scan of spine	○	○	
Liver scan	○	○	
Bone scan	○	○	
Neck X-rays	○	○	
Back X-rays	○	○	
MRI	○	○	
Bone Density Test	○	○	
Blood Tests	○	○	
Other (describe)			

Operations	Yes	No
Tonsillectomy	○	○
Tubes in Ears	○	○
Appendectomy	○	○
Gall Bladder	○	○
Hernia	○	○
Hysterectomy	○	○
Dental Surgery	○	○
Other (describe)		

Hospitalizations	
When	**For What Reason**

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Please mark P for in the **Past, C** for **Currently** have and **N** for **Never**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

List Prescription & Non-Prescription drugs you take:_____

_____

_____

Women Specific

Check the box if yes and provide number.

☐ Pregnancies _____ ☐ Miscarriage _____ ☐ Living Children _____ ☐ Abortion _____ ☐ Cesarean _____

☐ Vaginal Delivery _____ ☐ Postpartum Depression _____ ☐ Toxemia _____ ☐ Baby Over 8 Pounds _____

☐ Gestational Diabetes _____

Menstrual History

Age At 1st Period _____ Menses Frequency _____ Length _____

Painful? ◯ Yes ◯ No Clotting? ◯ Yes ◯ No Have you ever missed your period? ◯ Yes ◯ No

For how long? _____ Are you menopausal? ◯ Yes ◯ No Age At Menopause _____

Last Menstrual Period _____

Do you take any hormone contraception? ☐ Birth Control Pill ☐ Patch ☐ Nuva Ring

I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify iit to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to Peak Health Center. I authorize Peak Health Center and its staff to examine and treat my condition as the practitioners see fit. I hereby authorize Peak Health Center to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me and that I am responsible for timely payment of such services. I understand and agree that verifying insurance benefits does not guarantee payment from my insurance company. I understand that there is a 48 hour cancellation policy for new patient and consultation appointments. Failure to comply with the cancellation policy may result in additional charges or fees. By submitting this paperwork, I agree to the policy as described above and will adhere to all of its practices.

By typing or signing your name below on the signature line, you are agreeing to all of the paragraph above.

_____

Signature Date

Thank you!