Dr. Megan Cloud, D.C.

## Patient Information

*Thank you for choosing our practice for your chiropractic needs.*
*If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.*

Name: (First) ______________________________ (Last) ______________________________

Date: ______________________________ I would like to be called: ______________________________

Address: ______________________________ City: ______________ State: __________ Zip: ______

Phone: Home: ____________________ Work: ____________________ Cell: ____________________

Birthdate: __________ Age: ________ Height: _______ Weight: ________ Social Security #: ________________

Are you? ☐ Male ☐ Female ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other

Do you have children? ☐ Yes ☐ No Ages: ______________________________

Your Employer: ______________________________ Occupation: ______________________________

Business Address: ______________________________ City: ______________ State: __________ Zip: _______

Spouse's or Parent's Name: ____________________ Workplace: ______________ Work Phone: __________

Whom may we thank for referring you to us? ______________________________

## Symptoms

Reason for visit: ______________________________

When did your problem begin? ______________________________

Did it begin ☐ suddenly ☐ gradually ☐ progressively over time

Did it start from an injury: ☐ Yes ☐ No what happened? ______________________________

Is this condition getting: ☐ Better ☐ Worse ☐ staying the same

Have you experienced a similar problem before? ______________________________

Where specifically is the problem(s) located? ______________________________

Type of pain: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Spasm ☐ Throbbing

☐ Burning ☐ Numbness ☐ Tingling

Rate the severity of your pain (1 – no pain or discomfort to 10 – severe pain):

0 1 2 3 4 5 6 7 8 9 10

Is the pain constant? ______________________________

What makes it better? ______________________________

What makes it worse? ______________________________

What treatment have you already received for your condition? ______________________________

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other______________________

Name and address of other practitioner(s) who have treated you for your condition: ______________________

______________________________________________________________

Other areas of concern: ______________________________

______________________________________________________________

______________________________________________________________

## Health History

Check conditions that apply

| | | | |
|---|---|---|---|
| □ Abnormal Weight Loss | □ Bronchitis | □ Gout | □ Osteoarthritis |
| □ Abnormal Weight Gain | □ Cancer, Type: ______________ | □ Heart Disease | □ Osteoporosis |
| □ AIDS/HIV | □ Depression | □ High Blood Pressure | □ Pacemaker |
| □ Alcoholism | □ Diabetes | □ High Cholesterol | □ Restless Leg Syndrome |
| □ Anemia | □ Disc Disorder | □ Jaw Pain | □ Rheumatoid Arthritis |
| □ Anxiety | □ Dizziness | □ Kidney Disorder | □ Scoliosis |
| □ Asthma | □ Fatigue | □ Lyme Disease | □ Stroke |
| □ Back Pain | □ Fibromyalgia | □ Menstrual Pain | □ Thyroid Disease |
| □ Bladder Infection | □ Frequent Urination | □ Migraine Headaches | |

Other: ______________________________________________________________

Date of last medical exam? ______________________________ Who did you see? ______________________

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No

List any surgeries you have had and any times you have been hospitalized (include dates):

______________________________________________________________

______________________________________________________________

List any accidents or injuries and the dates they occurred (include broken bones):

______________________________________________________________

______________________________________________________________

Please list all medications that you are currently taking and the reasons:

______________________________________________________________

______________________________________________________________

Have you ever been seen by a chiropractor before? □ Yes □ No When? ______________________________

For what condition? ______________________________________________________________

## Family History

Does anyone in your family have a condition similar to yours? □Yes □ No Who? ______________________

Does anyone in your family have?

| | | | |
|---|---|---|---|
| □ Arthritis, Type: ____________________ | □ Back Pain | □ Diabetes | □ Disc Disorders |
| □ Cancer, Type: ____________________ | □ Heart Disease | □ High Blood Pressure | □ Neck Pain |
| □ Headache, Type: ____________________ | □ Scoliosis | □ Stroke | |

## Daily Habits

What type of exercise do you perform? ______________________________________________

What do your daily work habits include (i.e.: sitting, standing, light labor, heavy labor, computer work):

______________________________________________________________

What vitamins do you currently take? ______________________________________________

What kind of other nutritional supplements do you take (if any)? ______________________________

Do you smoke? □ Yes (How many packs per day? __________) □ Never Smoker □ Former Smoker

How much alcohol do you consume per day? ______________________ Caffeinated Beverages? ____________________

## Authorization

I certify that I have read and understand, and answered the above information to the best of my knowledge. I authorize Dr. Tedesco to perform a chiropractic evaluation, and if appropriate, treatments for my condition. I authorize Healing Hands Chiropractic to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Healing Hands Chiropractic insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

**X**______________________________________________________________

Signature of Patient (or parent if a minor) Date