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