Zui of Chiropractic
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Patient History Form

Today's Date: _____ Name: _____ Date of Birth: _____
Address: _____ City: _____ State: ___ Zip: _____
Phone (Home): _____ (Work): _____ (Cell): _____
Employer: _____ Occupation: _____
Insurance Company: _____ Primary Care Physician: _____ Last Visit: _____
E-mail Address: _____ Emergency Contact/Phone: _____
Height: _____ Weight: _____ Who referred you to our office? _____
Have you ever had chiropractic care before? *(Circle)* YES NO
If YES, Who/When?_____

YOUR CURRENT PROBLEM

Chief Complaint(s): (*Circle the intensity of each, scale of 1-10 with 10 being the worst*)

Headaches:	1	2	3	4	5	6	7	8	9	10
Shoulder L/R:	1	2	3	4	5	6	7	8	9	10
Mid-Back:	1	2	3	4	5	6	7	8	9	10
Leg L/R:	1	2	3	4	5	6	7	8	9	10
Arm L/R:	1	2	3	4	5	6	7	8	9	10
Neck Pain:	1	2	3	4	5	6	7	8	9	10
Lower Back:	1	2	3	4	5	6	7	8	9	10
Other: ____	1	2	3	4	5	6	7	8	9	10

Onset of Problem: Date ___/___/_____ *(Circle)* Unknown Gradual Sudden

Have you had this problem before? *(Circle)* YES NO If YES, When? _____

How did it start? *(Circle)* Exertion/Positional Auto Trip/Fall Repetitive Unknown
Other:_____

How long have you had it? ____Days ____Weeks ____Months ____Years

What does it feel like? *(Circle all that apply)* Dull/Achy Sharp Burning
Shooting/Knifelike Numbness/Tingling Dizziness/Nausea Muscle Weakness

Duration of symptoms during the day: *(Circle)*
Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (0-25%)

Are you taking or have taken any medication for this problem? *(Circle)* YES NO
If YES, please explain: _____

Are you taking any other medications? *(Circle)* YES NO
If YES, please explain:_____

Are you taking any vitamins/ herbs/ supplements? *(Circle)* YES NO
If YES, please explain:_____

Is this problem currently improving? Or, is it getting worse? *(Circle)*
Rapidly Improving Improving Slowly About the Same Gradually Worsening On & Off

Any bowel or bladder problem since this problem began? *(Circle)* YES NO
If YES, please explain: _____

Please tell us if any of these activities are being affected by your current symptoms:
(Put "O" if you feel BETTER or "X" if you feel WORSE)

__Lifting __Bending __Walking __Sitting __Standing __Stairs
__Reaching __Pushing __Pulling __Gripping __Exercise __Balance
__Squatting __Sleeping __Reading __Resting __Heat __Cold
__Driving __Kneeling __Other: _____

PAST HISTORY

Any major accidents or injuries? *(Type, year)*_____

Any surgeries? *(Type, year)* _____

Please indicate if you or a family member have had any of the following:
*(Write "**S**" for SELF or "**F**" for FAMILY)*

__Heart Disease __Diabetes __Stroke __Cancer
__High Blood Pressure __Ashthma __Gastrointestinal disease
__Memory/Mood Disorder __Thyroid Problem

Please indicate if you have or have had any of the following:
*(Write "**C**" for CURRENT PROBLEM or "**P**" for PAST PROBLEM)*

__Visual disturbances __Chest pain __Shortess of breath __Ringing in ears
__Cold sweats __Sleeping problems __Fainting spells __Dizziness
__Fainting __Loss of balance __Upset stomach __Diarrhea
__Constipation __Rapid weight change __Light bothers eyes __Ulcers
__Pins&Needles in hands/toes __Cold hands/feet __Painful joints
__Excessive fatigue __Sinus problems __Loss of smell
__Gall bladder problems __Kidney Problems __Indigestion/reflux
__Menstrual irregularity/cramps __Numbness in fingers/toes

Do you smoke? (*Circle*) YES NO
If YES, please describe (*amount*):_____

FEMALES: Are you pregnant? (*Circle*) YES NO NOT SURE

Authorization and Consent

- I hereby request medical services by Zui of Chiropractic LLC. I understand that there may be risks involved with and alternatives to medical treatment proposed by Zui of Chiropractic LLC. I understand that I always have the right to ask detailed questions about all aspects of my treatment. I consent to services provided and rendered by the staff of Zui of Chiropractic LLC.
- I have requested, as a courtesy to me, that my insurance company be billed for any/all services rendered to me at Zui of Chiropractic LLC. However, I understand that I am personally responsible for payment of all bills for services.
- I authorize release of information in my medical records and history to the staff of Zui of Chiropractic LLC. I authorize release of information in my medical records and history to my insurance company when required by the insurance company to pay any medical bills incurred by me at Zui of Chiropractic LLC. I authorize release of medical history, both verbally and in writing, to my physician when Zui of Chiropractic LLC staff are working under referral.
- I authorize use of my name, phone number, email address, and clinical records to contact me with appointment reminders or to discuss treatment alternatives. I authorize Zui of Chiropractic LLC and its representatives to leave messages on the voicemail of the number I provided regarding the above. I do reserve the right to revoke this consent in the future if I request it in writing.

Patient's Signature _____ Date _____

(For patients under 16 or those unable to sign for themselves)
Signature Authorizing Care _____ Date _____