Secrest Family Chiropractic, pc

Dr. Daniel P. Secrest, DC
3350 N. Hayden Road, Ste. 112
Scottsdale, AZ 85251
Phone 480-994-4411
Fax 480-994-4421

PATIENT HISTORY

TODAY'S DATE _____

DATE OF BIRTH _____

NAME _____

SOCIAL SECURITY # _____

SPOUSE'S NAME _____

CHILDREN'S NAMES & AGES _____

_____

ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP _____

PHONE (H) _____ (W) _____

CELL _____ EMAIL _____

OCCUPATION _____

EMPLOYER _____

EMPLOYER ADDRESS _____

_____

INSURANCE COMPANY _____

POLICY # _____

HAVE YOU EVER BEEN TO ANOTHER DOCTOR FOR THIS PROBLEM? _____

WHO? _____

HAVE YOU EVER BEEN TO A CHIROPRACTOR FOR THIS PROBLEM? _____

WHO? _____

WHO REFERRED YOU TO THIS OFFICE? _____

FIRST EPISODE? _____

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FIRST COMPLAINT: _____

***Date when symptom first appeared** _____

Did it begin:

Gradual _____ Sudden _____ Progressive over time _____

How often do you experience the symptoms?

◯ Constant 100% ◯ Frequent 75%

◯ Intermittent 50% ◯ Occasional 25% ◯ Rare 10%

Describe any recently related accident or fall _____

_____

_____

What makes symptom increase? _____

What gives relief of symptom? _____

Type of pain:

◯ Sharp ◯ Dull ◯ Aching ◯ Burn

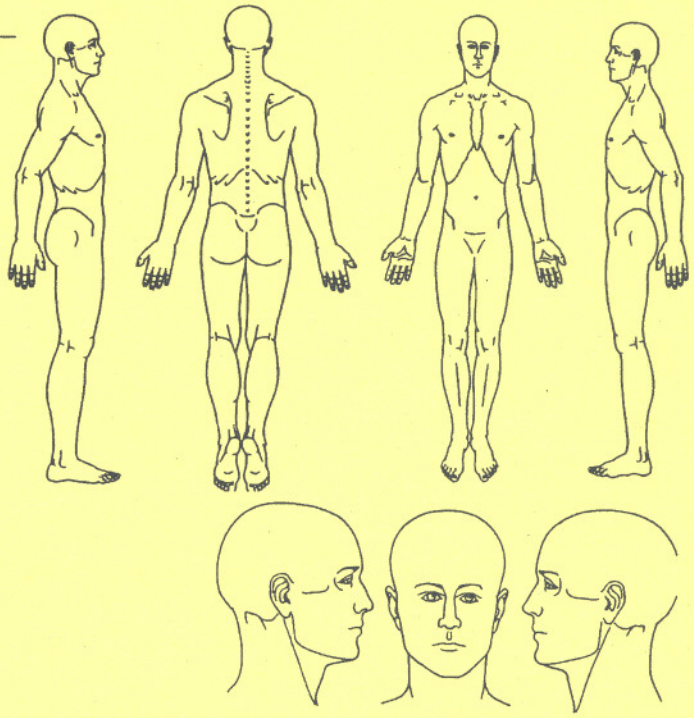
◯ Throb ◯ Numb ◯ Other _____

Where does the pain radiate to? _____

How bad is your pain (indicate 0 no pain to 10 unbearable)

0 ——————— 5 ——————— 10

Please mark your areas of pain on the figures below



DOCTORS NOTES

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(OPTIONAL)SECOND COMPLAINT: _____

***Date when symptom first appeared** _____

Did it begin:

Gradual _____ Sudden _____ Progressive over time _____

How often do you experience the symptoms?

◯ Constant 100% ◯ Frequent 75%

◯ Intermittent 50% ◯ Occasional 25% ◯ Rare 10%

Describe any recently related accident or fall _____

_____

What makes symptom increase? _____

What gives relief of symptom? _____

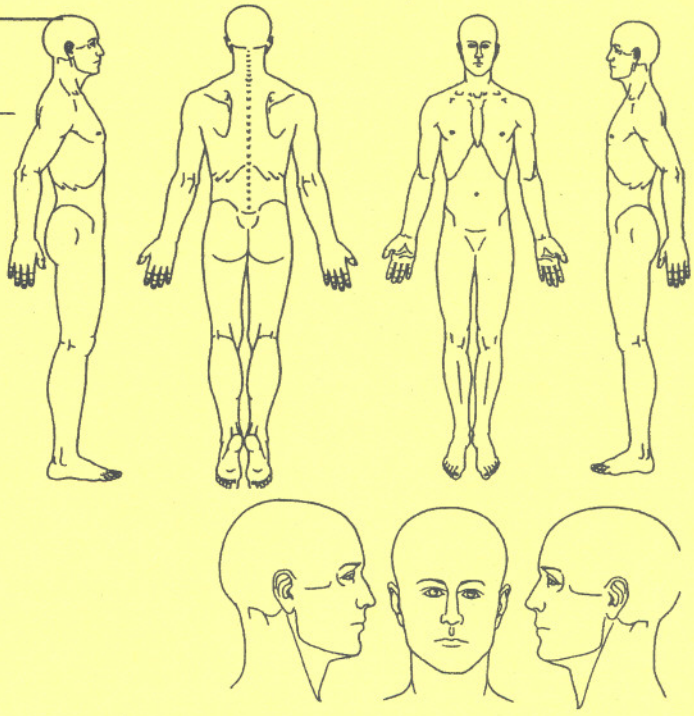
Type of pain:

◯ Sharp ◯ Dull ◯ Aching ◯ Burn

◯ Throb ◯ Numb ◯ Other _____

How bad is your pain (indicate 0 no pain to 10 unbearable)

0 ——— 5 ——— 10



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(OPTIONAL)THIRD COMPLAINT: _____

***Date when symptom first appeared** _____

Did it begin:

Gradual _____ Sudden _____ Progressive over time _____

How often do you experience the symptoms?

◯ Constant 100% ◯ Frequent 75%

◯ Intermittent 50% ◯ Occasional 25% ◯ Rare 10%

Describe any recently related accident or fall _____

_____

What makes symptom increase? _____

What gives relief of symptom? _____

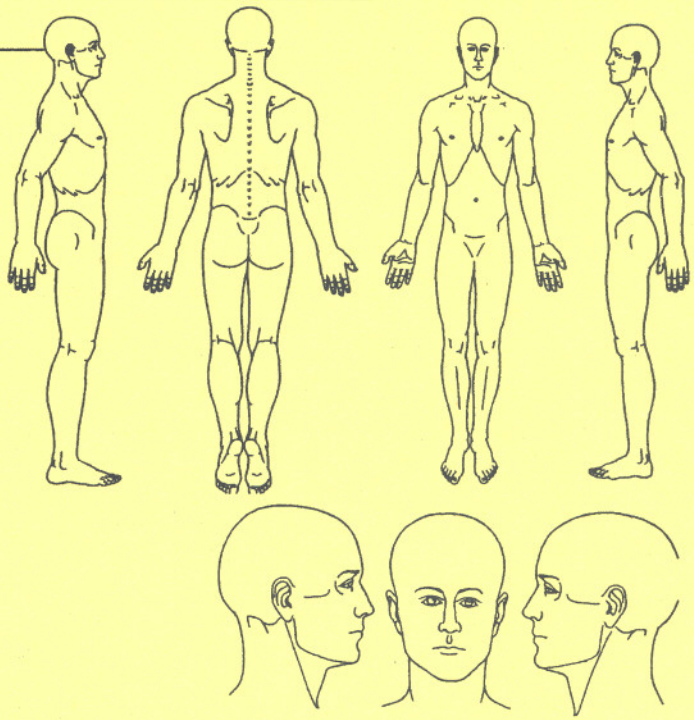
Type of pain:

◯ Sharp ◯ Dull ◯ Aching ◯ Burn

◯ Throb ◯ Numb ◯ Other _____

How bad is your pain (indicate 0 no pain to 10 unbearable)

0 _____ 5 _____ 10



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PLEASE LIST ALL PREVIOUS TREATMENTS FOR THIS CONDITIONS

1) Name _____
Phone # _____
Dates of care _____
Tests/Treatments _____
Results _____

2) Name _____
Phone # _____
Dates of care _____
Tests/Treatments _____
Results _____

HOW HAS THIS AFFECTED YOUR LIFE

	CIRCLE ONE	
Have you missed work?	YES	NO
Has the quality of your work been affected?	YES	NO
Would you rather work with or without the pain?	WITH	WITHOUT
Are you able to do household chores?	YES	NO
Has this problem interferred with your social life?	YES	NO
Has it interfered with spending time with family and freinds?	YES	NO
Has it interfered with your recreational activities (Exercise, Golf, Tennis,Fishing, etc...)	YES	NO

Has it affected your life in any other way? _____

_____

PLEASE LIST ALL SUGERGIES YOU HAVE HAD

Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____

PLEASE LIST ALL PREVIOUS ACCIDENTS AND FALLS

What _____ When _____
What _____ When _____
Remarks _____

PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU TAKE

What _____ Frequency _____ Doctor _____
What _____ Frequency _____ Doctor _____
What _____ Frequency _____ Doctor _____

DISABILITY

Do you have a permenant disability rating? _____ Location _____ Date received _____
Rating Percentage _____

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OCCUPATIONAL INFORMATION

Job Involves:

○Sitting ○Standing How long _____ ○Desk ○Counter ○Other _____

○Lifting How much weight_____ ○Bending ○Stooping ○Twisting ○Turning

Type of shoes ○High heels ○Boots ○Arch supports ○Other _____

How long do you speak on the telephone each day_____ ○Traditional telephone receiver ○Headset

Physical activity at work ○Sedentary ○Light manual labor ○Manual labor ○Heavy manual labor

Do any of your work activities aggravate your present main complaints? Please describe _____

_____

HEALTH HABITS: How much per day or week?

Tea, coffee _____ Liqour _____ Tobacco _____ Sugar, candy, ice cream _____

Exercise: 1)Type_____ Frequency _____ 2) Type _____ Frequency_____

Sleep: Hours per night_____ Type of mattress_____ Naps_____

Do you sleep on your ○ Back ○ Side ○ Stomach

Please describe your sleep_____

Special diets _____

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD

○ HIV Positive	○ Goiter	○ Tuberculosis	○ Diabetes	○ Malaria	○ Pneumonia
○ Anemia	○ Gout	○ Typhoid Fever	○ Diptheria	○ Measles	○ Polio
○ Appendicitis	○ Heart Disease	○ Ulcers	○ Eczema	○ Miscarriage	○ Rheumatic Fever
○ Arteriosclerosis	○ Herpes	○ Venerial Infection	○ Emphysema	○ Multiple Sclerosis	○ Scarlet Fever
○ Arthritis	○ Influenza	○ Whooping Cough	○ Epilepsy	○ Mumps	○ Stroke
○ Cancer	○ Lumbago	○ Cold Sores	○ Hypersensitivity	○ Pleurisy	○ Other_____
○ Fibromyalgia	○ Small Pox	○ Allergies	○ Asthma	○ Chicken Pox	_____

X-RAY CONFIRMATION

This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

_____ _____

Patient Signature Date

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge

_____ _____

Patient Signature Date

DOCTORS NOTES