Dr. Barbara Jennings
Natural Health In Real Life

CONFIDENTIAL HEALTH INFORMATION

All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

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Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

Whom may we thank for referring you? ◯ No ◯ Yes **When?** _____ **If so, whom?**

Gender

Your Last Name ◯ Male ◯ Female **Your Social Security Number**

Your First Name **Your Middle Name or Initial** **Today's Date (MM/DD/YYYY)**

Marital Status
◯ Single ◯ Married ◯ Divorced
◯ Widowed ◯ Separated

Address

City **State/Province** **ZIP/Postal Code** **Home Phone** **Spouse's Name**

Email Address **Cell Phone** **Child's Name and Age**

Emergency Contact **Phone** **Child's Name and Age**

Your Occupation **Child's Name and Age**

Your Employer

May we contact you at work?
◯ Yes ◯ No

Address

City **State/Province** **ZIP/Postal Code** **Work Phone**

Insurance Carrier **Policy Number**

Insured's Last Name **Birth Date (MM/DD/YYY)**

First Name **Middle Name or Initial**

Insured's Employer

Address

City **State/Province** **ZIP/Postal Code** **Employer's Phone**

CONFIDENTIAL HEALTH INFORMATION

Patient Name

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle): ◯ An accident or injury

◯ Work ◯ Auto ◯ Other _____

◯ A worsening long-term problem

◯ An interest in: ◯ Wellness Other _____

3. Onset (When did you first notice your current symptoms?)

_____

4. Intensity (How extreme are your current symptoms?)

1 ◯◯◯◯◯◯◯◯◯ 10

Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)

◯ Constant ◯ Comes and goes

How often? _____

6. Quality of symptoms (What does it feel like?)

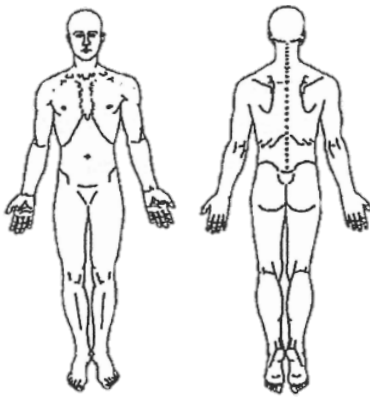
◯ Numbness ◯ Nagging
◯ Tingling ◯ Sharp
◯ Stiffness ◯ Burning
◯ Dull ◯ Shooting
◯ Aching ◯ Throbbing
◯ Cramps ◯ Stabbing
◯ Other _____

_____

_____

_____

7. Location (Where does it hurt?) Circle the area(s) on the illustration.
"O for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities)

What tends to worsen the problem?

_____

What tends to lessen the problem?

_____

10. Prior interventions (What have you done to relieve the symptoms?)

◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic ◯ Massage
◯ Physical therapy Other _____

11. What else should Dr. Jennings know about your condition? _____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		◯ None
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders	Initials
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture	_____

b. Neurological

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		◯ None
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness	Initials
																		_____

c. Cardiovascular

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		◯ None
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising	Initials
																		_____

d. Respiratory

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		◯ None
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia	Initials
																		_____

e. Digestive

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		◯ None
◯	◯	Anorexia/ bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea	Initials
																		_____

f. Sensory

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		◯ None
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste	Initials
																		_____

g. Integumentary

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		◯ None
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash	Initials
																		_____

Doctor's initials

Barbara L. Jennings, D.C.
Health Summit Chiropractic

Patient Name

h. Endocrine

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		○ None
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low	Initials

i. Genitourinary

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		○ None
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	Initials

j. Constitutional

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE		○ None
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight change	○	○	Weakness	Initials

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

HAD	HAVE		HAD	HAVE	
○	○	AIDS	○	○	Mumps
○	○	Alcoholism	○	○	Polio
○	○	Allergies	○	○	Rheumatic fever
○	○	Arteriosclerosis	○	○	Scarlet fever
○	○	Cancer	○	○	Sexually transmitted disease
○	○	Chickenpox			
○	○	Diabetes	○	○	Stroke
○	○	Epilepsy	○	○	Tuberculosis
○	○	Glaucoma	○	○	Typhoid fever
○	○	Goiter	○	○	Ulcer
○	○	Gout	○	○	Other _____
○	○	Heart _____			
○	○	Hepatitis _____			
○	○	Heart _____			
○	○	Hepatitis _____			
○	○	Malaria			
○	○	Measles			
○	○	Multiple sclerosis			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently.**

PAST	CURRENTLY	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements

LIST _____

○ ○ Medications (prescription and over-the-counter)

17. Injuries

Have you ever…

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

FAMILY

18. Family History Some health issues are hereditary. Tell Dr. Jennings about the health of your immediate family members.

Relative	Age (if living)	State of health	Illnesses	Age of death	Cause of death
Mother		○ ○			○ ○
Father		○ ○			○ ○
Sister 1		○ ○			○ ○
Sister 2		○ ○			○ ○
Brother 1		○ ○			○ ○
Brother 2		○ ○			○ ○
		○ ○			○ ○

19. Are there any other hereditary health issues you know about? _____

SOCIAL

20. Social History Tell Dr. Jennings about your health habits and stress levels.

Alcohol use	○ Daily	○ Weekly	How much? _____
Coffee use	○ Daily	○ Weekly	How much? _____
Tobacco use	○ Daily	○ Weekly	How much? _____
Exercising	○ Daily	○ Weekly	How much? _____
Pain relievers	○ Daily	○ Weekly	How much? _____
Soft drinks	○ Daily	○ Weekly	#Diet _____ #Non-Diet _____
Water intake	○ Daily	○ Weekly	How much? _____
Hobbies:			

Prayer or Meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

Doctor's initials

Barbara L. Jennings, D.C.
Health Summit Wellness

Patient Name

21. **Activities of Daily Living**

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of a car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard Work	○	○	○	○

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your preferred sleeping position? _____

26. Describe your typical eating habits:

___ Skip breakfast ___ Two meals a day ___Three meals a day ___ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

_____

○ All other systems negative

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statements and initial your agreement.

Initials

_____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ I realize than an X-ray examination may be hazardous to an unborn child and I certify the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment at the time of service of any covered or non-covered services I receive.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

If the patient is a minor child, print child's full name: _____

_____ Signature

_____ Date (MM/DD/YYYY)

Doctor's initials

Barbara L. Jennings, D.C.
Health Summit Wellness