Print Form

FALK FAMILY CHIROPRACTIC CENTER, PC

1501 Ninth Avenue • Conway, SC 29526 • 843-248-0104

Last Name: _____ First Name: _____ Middle Initial: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail _____

Street Address and Number: _____

Mailing Address (if different) _____

City, State and Zip Code: _____

Age: _____ Date of Birth: _____ Social Security #: _____

Sex: ☐ Male ☐ Female # of Children: _____ **Check One:** ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Race (check only 1) ☐ American Indian ☐ Alaska Native ☐ Asian ☐ White ☐ Black or African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Declined to State

Ethnicity (check only 1) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to State

Preferred Language _____

Employer: _____ Occupation: _____ Supervisor: _____

Employer Address: _____

Spouse's Name: _____ Spouse's Occupation: _____

Referred by: _____ Driver's License #: _____

In case of emergency, please contact (include phone #): _____

Do you have health insurance you would like us to file? ☐ **Yes** ☐ **No**

Please describe your major complaint: _____

_____

Name of person responsible for payment (if different from applicant): _____

I hereby authorize Dr. Falk to examine me, including x-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me. If Falk Family Chiropractic Center must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Falk Family Chiropractic Center for all costs of such collection efforts, including but not limited to all court cost and all attorney fees.

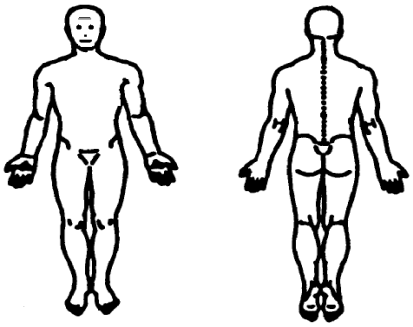
By signing your name below, you certify the accuracy of your medical and / or accident history and further certify that you present to Dr. Falk / Falk Family Chiropractic Center for evaluation and treatment of a health related condition and for no other purpose.

_____ _____

Signature of patient, or Guardian Authorizing care Date

File # _____

PLEASE MARK THE EXACT LOCATION OF YOUR PROBLEM ON THE DIAGRAM AT RIGHT →→→→→



USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS.

KEY A = ACHE B = BURNING
P = PINS & NEEDLES S = STABBING
N = NUMBNESS O = OTHER

A Are your present problems due to an injury? ❑ Yes—Enter the date of the injury: _____ ❑ No—skip to **B**

Was the injury? ❑ Job Related ❑ Auto Accident ❑ Personal Injury ❑ Other: _____
Has the accident been reported? ❑ Yes ❑ No If so, to whom? ❑ To Employer ❑ Auto Carrier ❑ Other: _____
Briefly describe the accident, injury or illness: _____

List symptoms immediately after injury. Mark severity for each symptom 5—10 (5 = Very Mild, 10 = VERY Severe)

Symptom	Severity	Symptom	Severity (1-4 = no pain)

List any tests, studies or medications received for this condition:
❑ Tests/Studies: _____
❑ Medications: _____
Where you admitted to the hospital due to this condition: ❑ Yes ❑ No
If yes, what hospital? _____ Transported by? ❑ Ambulance ❑ Police ❑ Other: _____
Date Admitted: _____ Date Released: _____ Length of Stay: _____
List the hospital procedures received: _____

B List symptoms you are experiencing today: Mark severity for each symptom 5—10 (5 = Very Mild, 10 = VERY Severe)

Symptom	Severity	Symptom	Severity (1-4 = no pain)

Date or Duration symptoms started _____ Date or Duration condition became worse _____

Mark Any Activities Which Aggravate Your Condition:
❑ Standing ❑ Walking ❑ Sitting ❑ Lying ❑ Bending ❑ Lifting ❑ Twisting ❑ Coughing ❑ Other _____

Is this condition interfering with ❑ Work ❑ Sleep ❑ Chores ❑ Routine ❑ Other _____ ?

Have You Seen Another Doctor For This Condition?
❑ MD ❑ Chiropractor ❑ Osteopath ❑ Acupuncturist ❑ Dentist ❑ Podiatrist ❑ Other _____
Do you have any current work restrictions due to this condition?

Off work: ❑ Yes ❑ No ❑ Previously From: _____ To: _____ Light duty: ❑ Yes ❑ No ❑ Previously
(If yes, what are/were your restrictions?) _____

What type of work do you do?
_____
Do you suffer from any condition other than that for which you are now consulting us? ❑ No ❑ Yes
_____

List any past conditions you may have had: _____
_____

File # _____

This is a personal and confidential case history. No information will be shared unless requested by you.

About Your Health

Throughout life, events occur which damage your health. This case history will uncover the layers of damage that resulted in poor health. Following your exam, we will outline a course of care to correct these layers of damage to recover your health potential.

C History

Yes	No		If Yes, Please Explain: explain here:
		Growth and Development	
☐	☐	Have you ever received Chiropractic Care	
☐	☐	Were you dropped as a baby?	
☐	☐	Childhood Sicknesses?	
☐	☐	Broken bones?	
☐	☐	Stitches?	
☐	☐	Did you fall down stairs?	
☐	☐	Were you yanked by your arm?	
☐	☐	Did you have other traumas as a child?	
☐	☐	Have you been in **any** accidents?	
☐	☐	Have you had **any** surgeries? (Specify date)	
☐	☐	Do you have occupational stress?	
☐	☐	Physical stress?	
☐	☐	Mental stress?	
☐	☐	Hobbies/Sports injuries?	
☐	☐	Sleeping habits (nightmares)?	

Sleeping posture ☐ Side ☐ stomach ☐ back

D Present State of Ill Health

Other Symptoms

☐ Headaches	☐ Pins & Needles in Legs	☐ Fainting	☐ Loss of Smell
☐ Neck Pain	☐ Pins & Needles in Arms	☐ Dizziness	☐ Loss of Taste
☐ Mid-Back Pain	☐ Numbness in Fingers	☐ Chest Pains	☐ Diarrhea
☐ Low Back Pain	☐ Numbness in toes	☐ Heartburn / reflex	☐ Constipation
☐ Shoulder Pain	☐ Elbow Pain	☐ Fatigue	☐ Tension
☐ Wrist Pain	☐ Shortness of Breath	☐ Feet Cold	☐ Stomach Upset
☐ Knee Pain	☐ Irritability	☐ Hands Cold	☐ Depression
☐ Ankle Pain	☐ Ringing in Ears	☐ Cold Sweats	☐ Loss of Balance
☐ Painful Tailbone	☐ Spinal Curvature (Scoliosis)	☐ Swollen Joints	☐ Tremors

Other _____

PLEASE CHECK THE BOX FOR EACH CURRENT OR PAST SYMPTOM LISTED.

GENERAL SYMPTOMS

- ☐ Bronchitis
- ☐ Chills (Constant)
- ☐ Convulsions
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Night Sweats
- ☐ Wheezing
- ☐ Sleeping Problems

CARDIO-VASCULAR

- ☐ Blood Pressure—High / Low
- ☐ Heart Trouble
- ☐ Poor Circulation
- ☐ Heart rate—rapid / slow
- ☐ Strokes

GASTRO-INTESTINAL

- ☐ Belching or Gas
- ☐ Colon Trouble
- ☐ Gall Bladder Trouble
- ☐ Hemorrhoids (piles)
- ☐ Nausea
- ☐ Stomach Pain
- ☐ Jaundice
- ☐ Liver Trouble
- ☐ Hernia
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Bloody Stools
- ☐ Irritable Bowel

NOSE/THROAT

- ☐ Asthma
- ☐ Deafness
- ☐ Earache
- ☐ Ear Discharge
- ☐ Ear Noises
- ☐ Thyroid Problems
- ☐ Frequent Colds
- ☐ Sinusitis
- ☐ Sore Throats
- ☐ Hay Fever
- ☐ Nasal Obstruction
- ☐ Nose Bleeds
- ☐ Pain in Eyes
- ☐ Poor Vision

EYE/EAR RESPIRATORY

- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Spitting Blood
- ☐ Spitting Phlegm

GENITO-URINARY

- ☐ Bed Wetting
- ☐ Blood in Urine
- ☐ Kidney Infection
- ☐ Frequent Urination
- ☐ Incontinent
- ☐ Painful Urination
- ☐ Kidney Stones
- ☐ Swelling Ankles
- ☐ Varicose Veins
- ☐ Tonsillitis
- ☐ Prostate Trouble

SKIN OR ALLERGIES

- ☐ Dryness ☐ Eczema ☐ Psoriasis
- ☐ Hives or Allergy ☐ Skin Eruptions
- ☐ Itching ☐ Sensitive Skin

FOR FEMALES ONLY

- ☐ Cramps ☐ Irregular Cycle
- ☐ Painful Periods ☐ Painful Periods
- ☐ Vaginal Discharge ☐ Pregnant Now?

_____ Last Pap Date _____ Last Menstrual Cycle

File # _____

E **HABITS**

☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Former Smoker ☐ Never Smoker

☐ Drinking Alcohol: (Cups/day): _____ ☐ Coffee Cups/Day: _____

☐ Soft Drink Bottles or Cans/Day: _____ ☐ Water Cups/Day: _____

EXERCISE

☐ None
☐ Moderate
☐ Daily

DIET (Do you eat Healthy foods?)

☐ Yes ☐ No
☐ Special diet _____
_____
☐ Food Allergies _____

F **FAMILY HISTORY**

	Diabetes	Cancer	Back Pain	Heart Disease	Other
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Sibling(s)	☐	☐	☐	☐	☐

G **Are you taking any medication** (prescription or over-the-counter)? ☐ Yes ☐ No

If Yes, please indicate the following:

Medication: _____
Route: Oral / Intravenous / Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

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Route: Oral / Intravenous / Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Have you taken any medications in the past? ☐ Yes ☐ No If yes, which ones?: _____

_____

Do you have allergies to medication? ☐ Yes ☐ No

If Yes, please indicate the following:

Allergy: _____
Reaction: _____
Start Date: _____ End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____ End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____ End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____ End Date: _____

Do you have other allergies (animal dander, dust, gluten, dairy…)? ☐ Yes ☐ No

If Yes, please indicate the following:

Allergy: _____
Reaction: _____
Start Date: _____ End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____ End Date: _____

H **DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?**

☐ Appendicitis	☐ Anemia	☐ Heart Disease	☐ Arthritis	☐ Pneumonia	☐ Measles	☐ Goiter
☐ Epilepsy	☐ Mumps	☐ Influenza	☐ Mental Disorder	☐ Polio	☐ Chicken Pox	☐ Pleurisy
☐ Tuberculosis	☐ Diabetes	☐ Alcoholism	☐ Rheumatic Fever	☐ Cancer	☐ HIV Positive	☐ Eczema
☐ Whooping Cough		☐ Gout	☐ Lupes	☐ Sarcoidosis	☐ Fibromyalgia	☐ Psoriasis