Kostidis Chiropractic Clinic

CONFIDENTIAL PATIENT INFORMATION Date: _____

Name:_____ **Hm. Phone**:_____ **Mobile Phone**:_____
Address:_____ **City**:_____ **State**:_____ **Zip**:_____
Age:_____ **Birth Date**:_____ **Email**:_____ **Gender**: M F
Race: American Indian Asian African American Caucasian Other:_____ **Ethnicity**: Hispanic/Latino Non-Hispanic/Latino
Language: English Spanish Other:_____ **Height**:_____ **Weight**:_____ **Blood Pressure**:_____ **Pulse**:_____
Emergency Contact:_____
Relationship Phone Number

SOCIAL HISTORY

Marital Status: M S W D **Name of Spouse**:_____ **Spouse's DOB**:_____
Smoking Habits: Light Everyday Someday Heavy Former None **Alcohol Use**: Casual Moderate Heavy Wine Beer None
Caffeine (drinks/day): <3 3-6 >6 **Drug Use**: Recreational Addiction None **Exercise Habits**: Daily Weekly Runner Walks Swimmer

EMPLOYMENT INFORMATION

Status: Employed Unemployed Retired Student **Occupation**:_____ **Employer**:_____
Address:_____ **City**:_____ **State**:_____ **Zip**:_____ **Phone**:_____

GUARANTOR/INSURANCE INFORMATION – **Any applicable copayments are required at time of service.**
You will be required to present your insurance card and photo ID at every visit.

	Primary Policy Holder	**Secondary Policy Holder**
Name		
Address		
City		
State, Zip		
Home Phone		
Work Phone		
Cell Phone		
Gender (M or F)		
Date of Birth		
Social Security #		
Relationship to Patient		
Insurance Company		
Group #		
Policy ID / Member #		
Employer		

Referred by:_____ Date of last physical exam:_____ Primary Care Physician:_____

Do you consent to receive prerecorded or automated calls such as reminder calls? Yes No **Contact Preference**: call text email

Primary purpose of this appointment:_____
Other doctor(s) seen for same/similar condition:_____

Do you wish to authorize any person(s), beside yourself, to have access to your protected health information, such as appointment times, account balances, imaging reports, etc.?
Name:_____ Relation:_____
Name:_____ Relation:_____
Name:_____ Relation:_____

I hereby confirm that the above information is accurate and true.

Patient's Signature:_____ SSN:_____ Date:_____

Guardian/Spouse or Guarantors Signature Authorizing Care:_____ Date:_____

MEDICAL HISTORY

Family History	If Living		If Deceased		Has any blood relative ever had:	Who	Please Circle	
	Birth Year	History	Death Year	Cause of Death				
Father					Cancer		No	Yes
Mother					Tuberculosis		No	Yes
Maternal Grandfather					Diabetes		No	Yes
Maternal Grandmother					Heart disease		No	Yes
Paternal Grandfather					High blood pressure		No	Yes
Paternal Grandmother					Bleeding tendency		No	Yes
Brother or Sister					Stroke		No	Yes
1					Epilepsy		No	Yes
2					Nervous breakdown		No	Yes
3					Kidney disease		No	Yes
4					Heart failure		No	Yes
Son or Daughter					**Note:** This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.			
1								
2								
3								

Personal History - Have you had any of the following: (Please circle yes or no)

Arthritis or Rheumatism	No	Yes	**X-RAYS –** Have you ever had x-rays of:			**NEUROLOGICAL**		
Any bone or joint disease	No	Yes	Neck	No	Yes	Frequent headaches	No	Yes
Bursitis, Sciatica or Lumbago	No	Yes	Back	No	Yes	Fainting spells	No	Yes
Polio	No	Yes	Other:	No	Yes	Convulsions	No	Yes
Migraine Headaches	No	Yes	If so, where did you have them done?			Paralysis or weakness	No	Yes
Hypertension	No	Yes				Dizzy spells	No	Yes
Diabetes	No	Yes				**EXTREMITIES**		
High or Low Blood Pressure	No	Yes				Arthritis	No	Yes
Nervous breakdown	No	Yes				Varicose veins	No	Yes
Other:	No	Yes	**Systems Review – Have you had any of the following?**			Cramps in legs	No	Yes
INJURIES – Have you had/been:			**EYES**			**MENSTRUATION (Women Only)**		
Broken or cracked bones	No	Yes	Eye strain	No	Yes	Do you currently get your period?	No	Yes
Lacerations	No	Yes	Seeing double	No	Yes	Are your periods regular?	No	Yes
Dislocations	No	Yes	Seeing halo around lights	No	Yes	Pain with periods	No	Yes
Concussion or head injury	No	Yes	**EARS**			Last period?		
Knocked unconscious	No	Yes	Hearing loss	No	Yes	**HEART & LUNGS**		
SURGERY - Have you had:			Infections	No	Yes	Chronic cough	No	Yes
Spinal fusion No Yes Date:			Ringing	No	Yes	Shortness of breath	No	Yes
Disc Surgery No Yes Date:			Earache or discharge	No	Yes	Night sweats	No	Yes
Pacemaker No Yes Date:			**NECK**			Chest pain or pressure	No	Yes
Other: Date:			Goiter	No	Yes	Palpitations or fluttering	No	Yes
Other: Date:			Lump or swelling	No	Yes	Swollen ankles	No	Yes
Other: Date:			Pain or stiffness	No	Yes	**INTESTINAL**		
Other: Date:			**KIDNEY & BLADDER**			Lump or swelling	No	Yes
Other: Date:			Albumin (protein) or sugar in urine	No	Yes	Discharge	No	Yes
Have you ever been advised to have any surgical operation which has not been done?	No	Yes	Blood in urine	No	Yes	Pain or stiffness	No	Yes
			Kidney or bladder infection	No	Yes	**GENERAL**		
Please explain:			Troubles urinating	No	Yes	Unusual fatigue	No	Yes
			INTESTINAL			Unusual weakness	No	Yes
			Loss of appetite	No	Yes	Abnormal thirst	No	Yes
			Trouble swallowing	No	Yes	Trouble sleeping	No	Yes
			Nausea	No	Yes	Anemia	No	Yes
			Vomiting	No	Yes	Swollen glands	No	Yes
Have you ever been hospitalized for any other illness?	No	Yes	Pain in abdomen	No	Yes	Skin trouble/Dermatitis	No	Yes
			Belching	No	Yes	Back Pain	No	Yes
Please explain:			Bloating	No	Yes	Neck Pain	No	Yes
			Constipation	No	Yes	Shoulder Pain	No	Yes
			Diarrhea	No	Yes	**OTHER:**		
			Blood in stools	No	Yes			
			Hemorrhoids	No	Yes			
			Change in bowel habits	No	Yes			

COMMENTS/CONCERNS:

Patient/Guardian Signature:_____ Reviewed by Physician:_____ Date: _____