HARMONY CHIROPRACTIC

Dr. Harmony White, D.C.
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**Who can we thank for referring you? _____

Personal History

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Mobile #: _____ Work #: _____

Home #: _____ Email: _____

***May we contact you via text for appointment reminders, schedule changes, etc.?** YES ☐ NO ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

SSN: _____ Date of Birth: _____ Age: _____

Sex / Gender: Male ☐ Female ☐

The following refers to dependent children:

Child's Name: _____ Age: _____ Health Conditions: _____

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Occupation: _____ Business/Employer: _____

Emergency Contact Information

Emergency Contact _____ Relationship: _____

Emergency Contact Phone Number: _____

Primary Care Physician: _____ Doctor's Phone Number _____

Financial Information

Who is responsible for this bill? Self ☐ Spouse ☐ Personal Insurance ☐ Medicare ☐ Auto Insurance ☐ Other ☐ _____

Primary Insurance: _____

Policy Holder: _____ Policy Holder's DOB: _____

Current Health Condition

Major Problem: _____

What caused the problem? _____

Doctor's seen for this: _____ When did it begin? _____

Is this problem job related? YES ☐ NO ☐ Is this problem auto related? Yes ☐ No ☐

List all medications: _____ What is it for? _____

_____ _____

_____ _____

_____ _____

Personal History

Surgeries or operations: _____ Date: _____

_____ Date: _____

Trauma: (Falls/Car accidents, etc.) _____ Date: _____

_____ Date: _____

Broken Bones: _____

Hospitalizations (other than above): _____

Previous Chiropractic Care? YES ☐ NO ☐ Name of Chiropractor/Clinic: _____

Previous X-rays: _____ Date: _____

Previous CT Scans: _____ Date: _____

Previous MRIs: _____ Date: _____

Tobacco use? YES ☐ NO ☐ If yes, how many packs per day? : _____

Caffeine use? YES ☐ NO ☐ If yes, what is the amount per day? : _____

Alcohol Use? YES ☐ NO ☐ If yes, how many drinks per week? _____

Exercise? YES ☐ NO ☐ If yes, how many times per week? _____

How many hours of sleep per night? _____ Hobbies: _____

Mother's Health Poor ☐ Fair ☐ Good ☐ Excellent ☐ Current Health Conditions: _____

Father's Health Poor ☐ Fair ☐ Good ☐ Excellent ☐ Current Health Conditions: _____

Sibling's Health Poor ☐ Fair ☐ Good ☐ Excellent ☐ Current Health Conditions: _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan, and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Appendicitis
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ HIV
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Smallpox
- ☐ Chicken Pox
- ☐ Alcoholism
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Eczema
- ☐ Venereal Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Allergies
- ☐ Stroke___
- ☐ Gout

CHECK ANY OF THE FOLLOWING YOU **CURRENTLY HAVE** OR **HAVE HAD** IN THE PAST 6 MONTHS:

Musculo-Skeletal Code
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint pain/Stiffness
- ☐ Walking Problems

Nervous System Code
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

General Code
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever

Genito-Urinary Code
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R Code
- ☐ Chest pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling

EENT Code
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Earaches
- ☐ Hearing Difficulty
- ☐ Stuffy Nose

Male/Female Code
- ☐ Menstrual Cramping
- ☐ Menstrual Irregularity
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes

Gastro-Intestinal Code
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Colitis
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Difficulty Chewing/Clicking Jaw
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stools

(*Female's Only)*
Are You Pregnant?
- ☐ Yes
- ☐ No
- ☐ Not Sure

Is there anything else you would like Dr Harmony to know about your health?

_____

_____

_____

Patient/Guardian Signature: _____ Date: _____