



CONFIDENTIAL HEALTH INFORMATION

Warner Family Chiropractic PC
Dr. David Warner, D.C.
1125 N. Galena Ave.
Dixon, IL 61021
(815) 284-9355
www.dixonchirocare.com

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

No Yes When?

Whom may we thank for referring you?

If so, whom?

Gender

Male Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth 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

Preferred method of contact?

Home Phone Cell Phone
 Work Phone Email

Address

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self Spouse Parent

First Name

Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

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

Patient name _____

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 _____

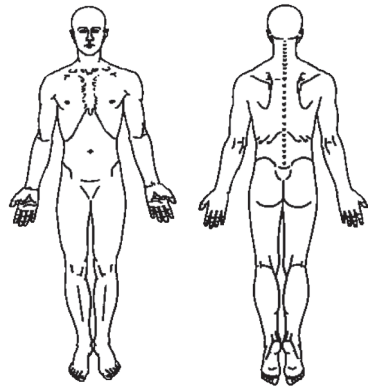
3. Onset (When did you first notice your current symptoms?)

4. Intensity (How extreme are your current symptoms?)
0 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
 - Tingling
 - Stiffness
 - Dull
 - Aching
 - Cramps
 - Nagging
 - Sharp
 - Burning
 - Shooting
 - Throbbing
 - 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, etc.)
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 Other _____
 Physical therapy Massage _____

11. What else should Dr. Warner know about your current 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 <input type="radio"/> Have <input type="radio"/> Osteoporosis	Had <input type="radio"/> Have <input type="radio"/> Arthritis	Had <input type="radio"/> Have <input type="radio"/> Scoliosis	Had <input type="radio"/> Have <input type="radio"/> Neck pain	Had <input type="radio"/> Have <input type="radio"/> Back problems	Had <input type="radio"/> Have <input type="radio"/> Hip disorders	NONE <input type="radio"/>
	<input type="radio"/> Knee injuries	<input type="radio"/> Foot/ankle pain	<input type="radio"/> Shoulder problems	<input type="radio"/> Elbow/wrist pain	<input type="radio"/> TMJ issues	<input type="radio"/> Poor posture	Initials _____
b. Neurological	Had <input type="radio"/> Have <input type="radio"/> Anxiety	Had <input type="radio"/> Have <input type="radio"/> Depression	Had <input type="radio"/> Have <input type="radio"/> Headache	Had <input type="radio"/> Have <input type="radio"/> Dizziness	Had <input type="radio"/> Have <input type="radio"/> Pins and needles	Had <input type="radio"/> Have <input type="radio"/> Numbness	NONE <input type="radio"/>
							Initials _____
c. Cardiovascular	Had <input type="radio"/> Have <input type="radio"/> High blood pressure	Had <input type="radio"/> Have <input type="radio"/> Low blood pressure	Had <input type="radio"/> Have <input type="radio"/> High cholesterol	Had <input type="radio"/> Have <input type="radio"/> Poor circulation	Had <input type="radio"/> Have <input type="radio"/> Angina	Had <input type="radio"/> Have <input type="radio"/> Excessive bruising	NONE <input type="radio"/>
							Initials _____
d. Respiratory	Had <input type="radio"/> Have <input type="radio"/> Asthma	Had <input type="radio"/> Have <input type="radio"/> Apnea	Had <input type="radio"/> Have <input type="radio"/> Emphysema	Had <input type="radio"/> Have <input type="radio"/> Hay fever	Had <input type="radio"/> Have <input type="radio"/> Shortness of breath	Had <input type="radio"/> Have <input type="radio"/> Pneumonia	NONE <input type="radio"/>
							Initials _____
e. Digestive	Had <input type="radio"/> Have <input type="radio"/> Anorexia/bulimia	Had <input type="radio"/> Have <input type="radio"/> Ulcer	Had <input type="radio"/> Have <input type="radio"/> Food sensitivities	Had <input type="radio"/> Have <input type="radio"/> Heartburn	Had <input type="radio"/> Have <input type="radio"/> Constipation	Had <input type="radio"/> Have <input type="radio"/> Diarrhea	NONE <input type="radio"/>
							Initials _____
f. Sensory	Had <input type="radio"/> Have <input type="radio"/> Blurred vision	Had <input type="radio"/> Have <input type="radio"/> Ringing in ears	Had <input type="radio"/> Have <input type="radio"/> Hearing loss	Had <input type="radio"/> Have <input type="radio"/> Chronic ear infection	Had <input type="radio"/> Have <input type="radio"/> Loss of smell	Had <input type="radio"/> Have <input type="radio"/> Loss of taste	NONE <input type="radio"/>
							Initials _____
g. Integumentary	Had <input type="radio"/> Have <input type="radio"/> Skin cancer	Had <input type="radio"/> Have <input type="radio"/> Psoriasis	Had <input type="radio"/> Have <input type="radio"/> Eczema	Had <input type="radio"/> Have <input type="radio"/> Acne	Had <input type="radio"/> Have <input type="radio"/> Hair loss	Had <input type="radio"/> Have <input type="radio"/> Rash	NONE <input type="radio"/>
							Initials _____

Consultation Notes

Doctor's Initials _____

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(Continued from previous page)

h. Endocrine

- Had Have Thyroid issues Had Have Immune disorders Had Have Hypoglycemia Had Have Frequent infection Had Have Swollen glands Had Have Low energy NONE

i. Genitourinary

- Had Have Kidney stones Had Have Infertility Had Have Bedwetting Had Have Prostate issues Had Have Erectile dysfunction Had Have PMS symptoms NONE

j. Constitutional

- Had Have Fainting Had Have Low libido Had Have Poor appetite Had Have Fatigue Had Have Sudden weight gain/loss (circle one) Had Have Weakness NONE

Patient name _____

Initials _____

Initials _____

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.	15. Operations Surgical interventions, which may or may not have included hospitalization.	16. Treatments Check the ones you've received in the Past or are receiving Currently .
	Had <input type="radio"/> Have <input type="radio"/> AIDS	<input type="radio"/> Appendix removal	Past <input type="radio"/> Currently <input type="radio"/> Acupuncture
	Had <input type="radio"/> Have <input type="radio"/> Alcoholism	<input type="radio"/> Bypass surgery	<input type="radio"/> Antibiotics
	Had <input type="radio"/> Have <input type="radio"/> Allergies	<input type="radio"/> Cancer	<input type="radio"/> Birth control pills
	Had <input type="radio"/> Have <input type="radio"/> Arteriosclerosis	<input type="radio"/> Cosmetic surgery	<input type="radio"/> Blood transfusions
	Had <input type="radio"/> Have <input type="radio"/> Cancer	<input type="radio"/> Elective surgery: _____	<input type="radio"/> Chemotherapy
	Had <input type="radio"/> Have <input type="radio"/> Chicken pox	<input type="radio"/> Eye surgery	<input type="radio"/> Chiropractic care
	Had <input type="radio"/> Have <input type="radio"/> Diabetes	<input type="radio"/> Hysterectomy	<input type="radio"/> Dialysis
	Had <input type="radio"/> Have <input type="radio"/> Epilepsy	<input type="radio"/> Pacemaker	<input type="radio"/> Herbs
	Had <input type="radio"/> Have <input type="radio"/> Glaucoma	<input type="radio"/> Spine _____	<input type="radio"/> Homeopathy
	Had <input type="radio"/> Have <input type="radio"/> Goiter	_____	<input type="radio"/> Hormone replacement
	Had <input type="radio"/> Have <input type="radio"/> Gout	_____	<input type="radio"/> Inhaler
	Had <input type="radio"/> Have <input type="radio"/> Heart disease	<input type="radio"/> Tonsillectomy	<input type="radio"/> Massage therapy
	Had <input type="radio"/> Have <input type="radio"/> Hepatitis	<input type="radio"/> Vasectomy	<input type="radio"/> Physical therapy
	Had <input type="radio"/> Have <input type="radio"/> HIV Positive	<input type="radio"/> Other: _____	<input type="radio"/> Nutritional supplements:
	Had <input type="radio"/> Have <input type="radio"/> Malaria	_____	List: _____
	Had <input type="radio"/> Have <input type="radio"/> Measles	_____	_____
Had <input type="radio"/> Have <input type="radio"/> Multiple Sclerosis	_____	_____	
Had <input type="radio"/> Have <input type="radio"/> Mumps	_____	_____	
Had <input type="radio"/> Have <input type="radio"/> Polio	17. Injuries Have you ever...	<input type="radio"/> Medications (prescription and over-the-counter):	
Had <input type="radio"/> Have <input type="radio"/> Rheumatic fever	<input type="radio"/> Had a fractured or broken bone	_____	
Had <input type="radio"/> Have <input type="radio"/> Scarlet fever	<input type="radio"/> Had a spine or nerve disorder	_____	
Had <input type="radio"/> Have <input type="radio"/> Sexually transmitted disease	<input type="radio"/> Been knocked unconscious	_____	
Had <input type="radio"/> Have <input type="radio"/> Stroke	<input type="radio"/> Been injured in an accident	_____	
	<input type="radio"/> Used a crutch or other support	_____	
	<input type="radio"/> Used neck or back bracing	_____	
	<input type="radio"/> Received a tattoo	_____	
	<input type="radio"/> Had a body piercing	_____	

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Dr. Warner about the health of your immediate family members.

FAMILY	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
			<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>
	Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

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

20. Social History

Tell Dr. Warner about your health habits and stress levels.

SOCIAL	Alcohol use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes <input type="radio"/> No
	Coffee use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes <input type="radio"/> No
	Tobacco use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes <input type="radio"/> No
	Exercising	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes <input type="radio"/> No
	Pain relievers	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes <input type="radio"/> No
	Soft drinks	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No
	Water intake	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____		
	Hobbies:	_____			

Doctor's Initials _____

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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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name _____

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? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

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

Initials _____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, 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.**

Initials _____ **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.**

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

Initials _____ **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.**

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

Initials _____ **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: _____

Consultation Notes

Doctor's Initials _____

**Warner Family
Chiropractic PC
Dr. David Warner, D.C.**

Signature _____

Date (MM/DD/YYYY) _____