



# 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](http://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?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Your Last Name

Your Social Security Number

Birth Date (MM/DD/YYYY)

Age

Your First Name

Your Middle Name (or Initial)

Gender

Male  Female

Race

Address

Marital Status  Married

Ethnicity

Single  Divorced

City

State/Province

ZIP/Postal Code

Widowed  Separated

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

Yes  No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

Home Phone  Cell Phone

Primary Care Provider's Name

Work Phone  Email

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self  Spouse  Parent

Insured's First Name

Insured's 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: \_\_\_\_\_

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 \_\_\_\_\_

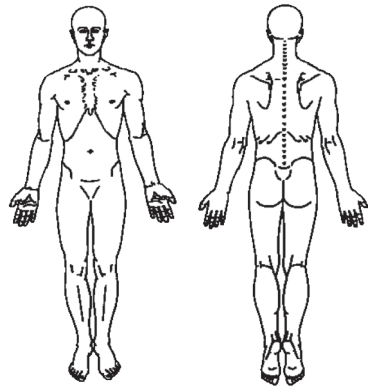
3. Onset (When did you first notice your current symptoms?)  
 \_\_\_\_\_

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.  
 "0" 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.

<b>a. Musculoskeletal</b>						
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Osteoporosis	<input type="radio"/> Arthritis	<input type="radio"/> Scoliosis	<input type="radio"/> Neck pain	<input type="radio"/> Back problems	<input type="radio"/> Hip disorders	Initials _____
<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	
<b>b. Neurological</b>						
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Anxiety	<input type="radio"/> Depression	<input type="radio"/> Headache	<input type="radio"/> Dizziness	<input type="radio"/> Pins and needles	<input type="radio"/> Numbness	Initials _____
<b>c. Cardiovascular</b>						
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> High blood pressure	<input type="radio"/> Low blood pressure	<input type="radio"/> High cholesterol	<input type="radio"/> Poor circulation	<input type="radio"/> Angina	<input type="radio"/> Excessive bruising	Initials _____
<b>d. Respiratory</b>						
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Asthma	<input type="radio"/> Apnea	<input type="radio"/> Emphysema	<input type="radio"/> Hay fever	<input type="radio"/> Shortness of breath	<input type="radio"/> Pneumonia	Initials _____
<b>e. Digestive</b>						
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Anorexia/bulimia	<input type="radio"/> Ulcer	<input type="radio"/> Food sensitivities	<input type="radio"/> Heartburn	<input type="radio"/> Constipation	<input type="radio"/> Diarrhea	Initials _____
<b>f. Sensory</b>						
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Blurred vision	<input type="radio"/> Ringing in ears	<input type="radio"/> Hearing loss	<input type="radio"/> Chronic ear infection	<input type="radio"/> Loss of smell	<input type="radio"/> Loss of taste	Initials _____
<b>g. Skin</b>						
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Skin cancer	<input type="radio"/> Psoriasis	<input type="radio"/> Eczema	<input type="radio"/> Acne	<input type="radio"/> Hair loss	<input type="radio"/> Rash	Initials _____

Consultation Notes

Patient name \_\_\_\_\_  
 Patient Number (office use only) \_\_\_\_\_

Doctor's Initials \_\_\_\_\_  
 Warner Family Chiropractic PC  
 Dr. David Warner, D.C.

(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

Initials \_\_\_\_\_

**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

Initials \_\_\_\_\_

**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

Initials \_\_\_\_\_

Patient name \_\_\_\_\_

Patient Number (office use only) \_\_\_\_\_

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.

<b>PERSONAL</b>	<b>14. Illnesses</b> Check the illnesses you have <b>Had</b> in the past or <b>Have</b> now.	<b>15. Operations</b> Surgical interventions, which may or may not have included hospitalization.	<b>16. Treatments</b> Check the ones you've received in the <b>Past</b> or are receiving <b>Currently</b> .
	Had <input type="radio"/> Have <input type="radio"/> AIDS	Had <input type="radio"/> Have <input type="radio"/> Tuberculosis	<b>Past</b> <input type="radio"/> <b>Currently</b> <input type="radio"/> Acupuncture
	Had <input type="radio"/> Have <input type="radio"/> Alcoholism	Had <input type="radio"/> Have <input type="radio"/> Typhoid fever	<input type="radio"/> Antibiotics
	Had <input type="radio"/> Have <input type="radio"/> Allergies	Had <input type="radio"/> Have <input type="radio"/> Ulcer	<input type="radio"/> Birth control pills
	Had <input type="radio"/> Have <input type="radio"/> Arteriosclerosis	Had <input type="radio"/> Have <input type="radio"/> Other: _____	<input type="radio"/> Blood transfusions
	Had <input type="radio"/> Have <input type="radio"/> Cancer	_____	<input type="radio"/> Chemotherapy
	Had <input type="radio"/> Have <input type="radio"/> Chicken pox	_____	<input type="radio"/> Chiropractic care
	Had <input type="radio"/> Have <input type="radio"/> Diabetes	_____	<input type="radio"/> Dialysis
	Had <input type="radio"/> Have <input type="radio"/> Epilepsy	_____	<input type="radio"/> Herbs
	Had <input type="radio"/> Have <input type="radio"/> Glaucoma	_____	<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"/> Massage therapy
	Had <input type="radio"/> Have <input type="radio"/> Hepatitis	_____	<input type="radio"/> Physical therapy
	Had <input type="radio"/> Have <input type="radio"/> HIV Positive	_____	<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	_____	<input type="radio"/> Medications (prescription and over-the-counter):	
Had <input type="radio"/> Have <input type="radio"/> Rheumatic fever	_____	_____	
Had <input type="radio"/> Have <input type="radio"/> Scarlet fever	_____	_____	
Had <input type="radio"/> Have <input type="radio"/> Sexually transmitted disease	_____	_____	
Had <input type="radio"/> Have <input type="radio"/> Stroke	_____	_____	
	<b>17. Injuries</b> Have you ever...	<input type="radio"/> Used a crutch or other support	
	<input type="radio"/> Had a fractured or broken bone	<input type="radio"/> Used neck or back bracing	
	<input type="radio"/> Had a spine or nerve disorder	<input type="radio"/> Received a tattoo	
	<input type="radio"/> Been knocked unconscious	<input type="radio"/> Had a body piercing	
	<input type="radio"/> Been injured in an accident		

Consultation Notes

**18. Family History**

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

<b>FAMILY</b>	<b>Relative</b>	<b>Age (If living)</b>	<b>State of health</b>		<b>Illnesses</b>	<b>Age at death</b>	<b>Cause of death</b>	
			<b>Good</b>	<b>Poor</b>			<b>Natural</b>	<b>Illness</b>
			<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.

<b>SOCIAL</b>	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 \_\_\_\_\_

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

**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 \_\_\_\_\_

Patient Number  
(office use only)

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) \_\_\_\_\_