

Czulada Chiropractic P.C.

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FILE # _____

DATE ___/___/___

Patient Initial Health History

Name _____ SS# _____ - _____ - _____

Street _____ City _____ St _____ Zip _____

Date of Birth: ___/___/___ Age: ___ Sex: M F Marital Status: M S W D

Home Phone _____ - _____ Cell Phone _____ - _____

Email _____

Your Employer _____ Your Occupation _____

Insurance Information (Please check type)

Medicare ___ Highmark ___ Group Coverage _____ Work Comp ___ Auto Injury ___

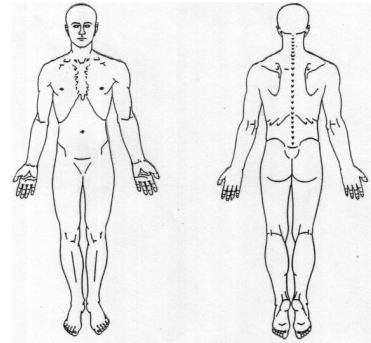
HMO _____ None ___ Pa Access(MA) _____

Primary Insured: Self ___ Spouse ___ Other ___

If other than Self: Insured's Name _____ D.O.B. _____ Employer _____

Please list the main reasons you are seeking our help:

1. _____ How Long Have You Had This? _____
2. _____ How Long Have You Had This? _____
3. _____ How Long Have You Had This? _____



How often are your symptoms present?

0 – 25% 26 – 50% 51 – 75% 76 – 100%

Mark your average pain over the last week

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0 1 2 3 4 5 6 7 8 9 10

Mark with an X on the picture where you have pain or other symptoms.

Family Physician _____

How were you referred to our office? _____

Last Visit to a Chiropractor? ___ Month ___ Year ___ Never

Do You Have a Pacemaker? Yes No

Could You Be Pregnant? Yes No

Records Release

Czulada Chiropractic Offices is authorized to obtain, examine & make copies of medical records, x-rays and reports pertaining to your treatment of my condition. This authorization is valid until revoked in writing by me. A photocopy of this authorization and my signature has same effect as the original.

Patient Signature _____ Date ___/___/___

Patient Initial Health History

Please mark all of the following that apply to you.

| NO | YES | Condition | NO | YES | Condition |
|-----------|------------|-----------------------------|-----------|------------|---------------------------------|
| | | History of recent infection | | | Recent Trauma |
| | | Recent fever | | | Prostate Problems |
| | | HIV/AIDS | | | Frequent urination |
| | | Diabetes | | | Pregnancy, # of births _____ |
| | | Corticosteroid use | | | Abnormal weight Gain Loss |
| | | Birth control pills | | | Epilepsy/ Seizures |
| | | High blood pressure | | | Visual Disturbances |
| | | Stroke (Date) _____ | | | History of Low/Mid back pain |
| | | Dizziness/ Fainting | | | History of neck pain |
| | | Numbness in Groin/ Buttocks | | | Arthritis |
| | | Urinary Retention | | | History of alcohol use |
| | | Aortic Aneurysm | | | History of tobacco use |
| | | Cancer/ Tumor | | | Surgeries/ Medications: |
| | | Osteoporosis | | | _____ |
| | | | | | _____ |

Family History:

- Cancer Diabetes
- High blood pressure Cardiovascular problems/ Stroke
- Back Problems Scoliosis