Weber Chiropractic ***Kirk W Weber DC***

Patient Name: _____Date: _____

Address_____City_____State_____Zip_____

H. Phone_____ W. Phone_____ C. Phone_____

Email address: _____

Sex M F Marital Status M S D W DOB_____ Age_____

Occupation _____

Employer _____

Referred by _____

Have you received chiropractic care before? Yes No If yes, when?_____

Name of most recent chiropractor _____

1. **Past health history**:

   A. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

   B. Previous injuries or Trauma: _____

   Have you ever broken any bones? Which? _____

   C. Allergies: _____

2. **Family Health History:**

   Do you have a family history of? (Please circle all that apply)

   Cancer Strokes/TIAs Headaches Heart disease Neurologic diseases

   Cardiac disease below age 40 Psychiatric disease Diabetes Other

Patient Name: _____Date: _____

A. Deaths in immediate family

Cause of parents' or siblings' death Age at death

_____

_____

_____

3. Social and Occupational History

A. Job description: _____
B. Work schedule: _____
C. Recreational activities: _____
D. Lifestyle:

Hobbies: _____

Level of exercise: _____

Alcohol use: _____

Tobacco use: _____

Diet: _____

4. Medications:

Medication Reason for taking

_____

_____

_____

_____

_____

_____

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Review of Systems

Circle any of the following lung issues you have or have had

Asthma COPD Emphysema Other _____

Circle any of the following heart issues you have or have had

Heart surgery Congestive heart failure Murmurs Heart attacks/Mis

Heart disease Hypertension Pacemaker Angina/chest pain Irregular beat

Other _____

Circle any of the following nerve related issues you have or have had

Visual changes/loss One sided weakness of face/body Seizures

One sided decreased feeling of face/body Headaches Memory loss

Tremors Vertigo Loss of smell Other _____

Circle any of the following gland/hormonal issues you have or have had

Thyroid disease Hormone replacement trmt Injected steroid replacements

Other _____

Circle any of the following kidney related issues you have or have had

Kidney stones Blood in urine Incontinence Bladder infections

Difficulty urinating Kidney disease Dialysis Other _____

Circle any of the following blood related issues you have or have had

Anemia Regular anti-inflammatory use (aspirin/Motrin/Tylenol) HIV +

Abnormal bleeding Enlarged lymph nodes Hemophilia Blood clots

Anticoagulant therapy Other _____

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Circle any of the stomach related issues you have or have had

Nausea Difficulty swallowing Ulcerative disease Frequent abdominal pain

Hiatal hernia Constipation Pancreatic disease Irritable bowel/colitis

Liver disease bloody or black tarry stool Vomiting blood

Bowel incontinence Gastroesophageal reflux/heartburn

Other _____

Circle any of the skin related issues you have or have had

Significant burns Significant rashes Skin grafts Psoriatic disorders

Other _____

Circle any of the following bone/muscle related issues you have or have had

Rheumatoid arthritis Gout Osteoarthritis Spinal Fracture Spinal surgery

Joint surgery Scoliosis Metal implants Other _____

Circle any of the following psychological issues you have or have had

Psychiatric diagnosis Depression Suicidal ideations Bipolar

Schizophrenia Psychiatric hospitalizations Other _____

Is there anything else in your history we should discuss? _____

_____

I have read the above information and certify it to be true to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care in accordance with PA statutes. If my insurance is billed, I authorize payment of medical benefits to Weber Chiropractic for services performed.

Patient or guardian signature _____

Date _____

1808 Route 422 East Fenelton, Pa. 1034 ***724-285-9093***