Covell Chiropractic
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COVELL
CHIROPRACTIC

New Patient Health History

Welcome to Covell Chiropractic! Please provide as much information regarding your health history as possible.

PERSONAL INFORMATION:

Patient Name: _____

Address:_____

City:_____ State:_____ Zip: _____

Primary Phone:_____ Work Phone:_____

Email Address:_____

DOB:_____/_____/_____ Age:_____ Gender: M / F

Marital Status: ___Single ___Married ___Other Are you enrolled in Medicare? Y / N

Occupation:_____

How did you hear about Covell Chiropractic? _____

Emergency Contact Information:

Name:_____

Relationship: _____Phone:_____

PRIMARY CONCERN: What brings you into the office today? _____

_____

_____

Was there an event (accident/illness/injury) that triggered your condition? Y / N

If yes, describe: _____

Date of original occurrence: _____Date of most recent: _____

How often do you experience symptoms? _____

What makes it better? _____ Worse? _____

If you experience pain, rate what it currently feels like on a scale of 0-10 (0 being no pain, 10 is the most pain):
Now: _____ At it's worst: _____

Does your pain radiate, shoot or travel? Y / N Where? _____

For the following questions, check all that apply:

What words describe what you feel:
___Numbness ___Aching ___Shooting ___Throbbing ___Swelling ___Sharp ___Dull ___Burning ___Cramps
___Tingling ___Constant Pain ___Intermittent Pain ___Pain worse at night ___Pain worse in the morning
___Pain worse w/ rest ___ Pain worse w/ activity

Symptoms interfere with: ___Work ___Daily Routine ___Sleep ___Recreation

Activities or movements that are difficult to perform: ___Standing ___Sitting ___Walking ___Running ___Bending
___Lying Down ___Stairs ___Other (Describe): _____

What have you tried to relieve your symptoms? ___Prescription Medication ___OTC Medication ___Acupuncture
___Ice ___Heat ___Physical Therapy ___Chiropractic ___Massage ___Nutrition
___Other (Describe):_____

Please list current medications (prescription, over the counter, birth control, vitamins, supplements/herbs) with frequency and dosage if known:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List any food or medication allergies: _____

Have you ever been hospitalized? Y / N Had surgery/surgeries? Y / N If yes list reason(s) and date(s):
_____
_____
_____

List any previous injuries: _____
_____
_____

Females: Are you pregnant? Y / N Due date: _____
Number of pregnancies: _____ Number of deliveries: _____ C-sections: _____
Complications with pregnancies: _____
Age at first period:_____ Usual Length of Cycle: _____ Complications: _____

FAMILY HISTORY: Please list ages and health problems (for example: cardiovascular disease, stroke, diabetes, cancer, arthritis). If deceased, list age at death and cause.
Father_____ Mother _____

Brother(s) _____ Sister(s) _____

Son(s) _____ Daughter(s) _____

GENERAL HISTORY:

Exercise	Work Activity	Habits:
Exercise: ___None ___Daily ___Moderate ___Heavy Types of Exercise:	___Sitting ___Standing ___Light Labor ___Heavy Labor Hours a day spent: Sitting: _____ Standing: _____	___Current Smoker Packs/Day _____ Are you interested in quitting? Y / N ___Former Smoker ___Never smoker How many alcoholic beverages do you consume: Per day _____ Per week _____ Recreational Drugs:_____

Do you consume coffee or caffeinated beverages? Y / N Number per day: _____
How much water do you drink per day? _____ Soda? _____
How many meals do you eat per day? _____ What are your typical eating habits?
_____
How many hours a night do you sleep? _____
Do you wake up feeling rested? Y / N Do you have difficulty falling asleep? Y / N
Do you wake up frequently? Y / N Do you experience frequent fatigue? Y / N

What is your preferred sleeping position? _____
What are the major stressors in your life? _____
Rate your emotional stress from 1-10 (1 least, 10 most) _____
Rate your physical stress from 1-10 (1 least, 10 most) _____
Have you experienced recent sudden weight loss or gain? Y/ N

What would be the most significant thing that would improve your health? _____

Additional health goals (current and future): _____

Complete the following information to the best of your knowledge:
Height: _____ Weight:_____ Blood Pressure:_____

REVIEW OF BODY SYSTEMS: Check all that apply. Please indicate severity (mild, moderate, severe) and dates if it is no longer a current problem.

Musculoskeletal: ___No Issues
___Osteoporosis ___Arthritis ___Scoliosis ___Neck Pain ___Back problems ___Hip Disorders
___Knee Injury ___Foot/Ankle ___Shoulder problems ___Elbow/Wrist ___TMJ Issues ___Poor Posture
__Other _____
Describe: _____
_____

Cardiovascular: ___No Issues
___High BP ___ Low BP ___High cholesterol __Bruising___Chest Pain ___Poor Circulation ___Murmur
___Shortness of Breath ___Leg Cramps ___Clotting Disorders ___Other_____
Describe:_____

Respiratory: ___ No Issues
___ Asthma ___ Apnea ___Emphysema ___Hay Fever ___Bronchitis ___Pneumonia ___Shortness of Breath
___Trouble breathing w/exercise ___Other_____
Describe:_____

Neurological: ___No Issues
___Anxiety ___Depression ___ Headaches ___ Dizziness ___ Fainting ___Seizures ___Numbness/Absence of Sensation
___Other _____
Describe: _____

Digestive: ___No Issues
___Eating Disorder ___Ulcer ___Food Sensitivity ___Heartburn ___Indigestion ___Nausea ___Diarrhea
___Stomach Pain ___Constipation ___Colitis ___Other_____
Describe:_____

Eyes/Ears/Nose/Throat: ___No Issues
___Blurred Vision ___Ringing in Ears ___Hearing Loss ___Loss of Smell ___Loss of Taste ___Ear infections
___Cataracts ___Glaucoma ___Nosebleeds ___Vertigo/Dizziness ___ Frequent Colds
___Frequent Sore Throat ___Swollen Glands ___Other_____
Describe:_____

Endocrine: ___No Issues
___Thyroid ___Immune Disorders ___Hypoglycemia ___Frequent Infection
___Low Energy ___ Diabetes ___Heat/Cold Intolerance ___ ExcessiveThirst ___Excessive Weight Loss/Gain
___ExcessiveHunger___ExcessiveSweating___Other_____
Describe:_____

Urinary: ___No Issues
___Kidney Stones ___Bedwetting ___Painful urination ___Frequent urination ___Other_____
Describe:_____

Skin: ___No Issues
___Skin Cancer ___Dry Skin ___Psoriasis ___Eczema ___Acne ___Hair loss ___Rash ___Varicose Veins ___Changes in hair/nails ___Other_____
Describe:_____

Females Only: ___No Issues
___Yeast Infections ___PCOS ___Abnormal Periods ___Discharge ____Infertility ___Menopause
___PMS Symptoms ___Sexually Transmitted Disease ___Decreased Libido ___Other_____
Describe: _____

Males Only: ___ No Issues
___ Erectile Dysfunction ___Prostate Issues ___Hernia ___ Sexually Transmitted Disease ___Vasectomy
___ Hernia ___Testicular Pain ___Other_____
Describe: _____

Are there any other past or current illnesses that you would like to describe?

_____

_____

Office Policies, Privacy Verification and Informed Consent for Treatment:

Payment:
Dr. Covell is not in contract with, nor does she participate with any insurance. Payments for appointments are due at the time of visit. Covell Chiropractic accepts all major credit cards, cash and checks.

Cancellation:
Out of courtesy to the staff at Covell Chiropractic, Phoenix Rising Therapeutic Massage and Bodywork and other patients, 24-hour advance notice is required for any cancellation. If 24 hours notice is not given, you will be billed the $20 missed appointment fee.

Confidentiality:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. You may request a copy of the Privacy Policy to be provided to you in paper form or via email. The Privacy Policy describes how your health information is protected and released on the patient's behalf for seeking reimbursement from any involved third parties. By signing below you acknowledge that you have been given the option to receive the Privacy Policy from Covell Chiropractic upon request.

Permission to Contact:
A patient may be contacted via phone or email to confirm or reschedule an appointment or be sent information from Dr. Covell as an extension of care in this office.

General Verification:
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.

Informed Consent for Treatment:
I understand that, as in all health care, there are some risks to chiropractic treatment. The risks include but are not limited to: bruising, soreness, worsening of symptoms, muscle strains, sprains, fractures, dislocations, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known to her, is in my best interest.

I understand that following my chiropractic consultation and exam I will receive information from my doctor about my condition and proposed chiropractic treatment program. This will include any anticipated benefits, the reasonably foreseeable risks and side effects of the treatment and alternatives to the proposed treatment, including no treatment.

I understand that I will have the opportunity to ask questions about my condition and the recommended care, and that I may ask further questions at any time.

Patient Signature: _____ Date: _____

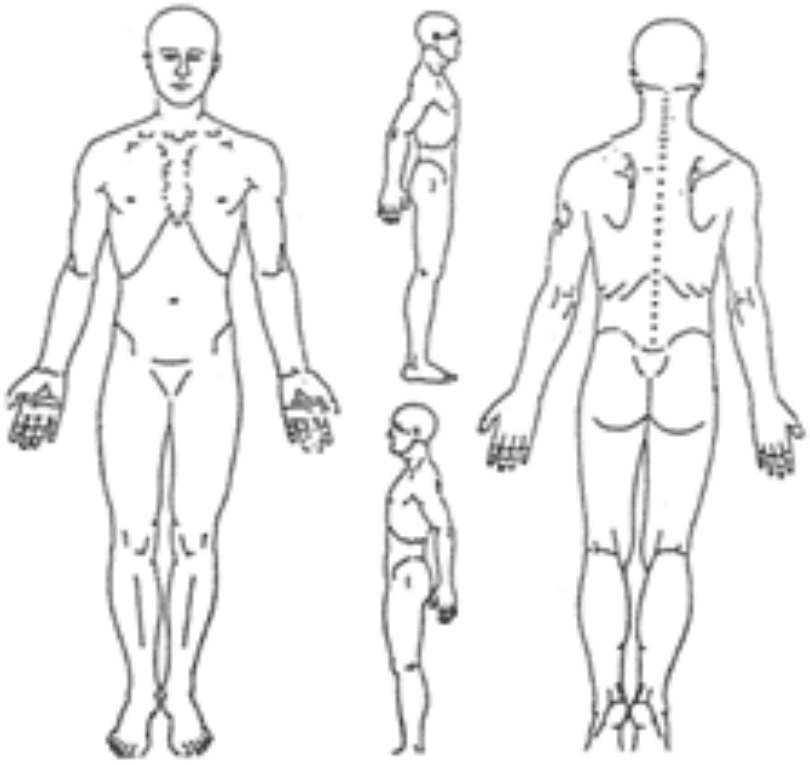
Pain Questionnaire

Please place a single vertical line through the scale below at the point that best describes your pain.
0 is no pain, 10 is the worst pain

Neck Pain: No pain[----------] Worst Pain

Back Pain: No pain [----------] Worst Pain

Other: _____ No Pain [----------] Worst Pain



Please mark the areas of your body where you feel the described sensations.

Use the appropriate symbols. Please do not just circle the area of involvement.

Numbness: ----

Pins and Needles: OOO

Burning: ***

Aching: XXX

Stabbing: ///

Other: **ΔΔΔ**

Patient Signature: _____ Date: _____