

STEEL CHIROPRACTIC CLINIC
1409 PIERSON DRIVE
CHARLOTTE, NORTH CAROLINA 28205
704-563-5001 PHONE * 704-563-5072 FAX

PERSONAL INFORMATION

NAME _____ DATE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE _____ SOC. SEC. NO. _____ DATE OF BIRTH _____
MARITAL STATUS _____ SEX _____ AGE _____ NUMBER OF CHILDREN _____
OCCUPATION _____ EMPLOYER _____
ADDRESS _____ CITY/ZIP _____ TELEPHONE _____
NAME OF SPOUSE _____ SPOUSE'S OCCUPATION _____
EMPLOYER _____
ADDRESS _____ CITY/ZIP _____ TELEPHONE _____
REFERRED BY _____

FINANCIAL AGREEMENT

I UNDERSTAND THAT ALL SERVICES ARE RENDERED ON A CASH, CHECK, OR CREDIT CARD BASIS. UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE AND APPROVED, I AGREE TO PAY FOR EACH SESSION AT THE TIME OF THE SESSION. I ALSO AGREE TO THE \$25 RETURNED CHECK CHARGE IN THE EVENT THAT MY CHECK IS RETURNED.

DATE _____ PATIENT'S SIGNATURE _____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT _____

HOW DID IT HAPPEN? _____

TODAYS CONDITION STARTED WHEN? _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? _____

WHAT ACTIVITIES LESSEN YOUR CONDITION? _____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY? _____

IS THIS CONDITION INTERFERING WITH WORK? _____ SLEEP? _____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE? _____

OTHER DOCTORS SEEN FOR THIS CONDITION _____

TYPE OF TREATMENT _____ RESULTS _____

HABITS

- ALCOHOL**
Type _____
Amount _____
- DIET**
Salt intake _____
Fat intake _____
Other _____
- SLEEP**
Difficulty falling asleep _____
Continuity disturbances _____
Early morning awakenings _____
Daytime drowsiness _____
Other _____

- SMOKING**
Packs daily _____
How long _____
Interested in stopping? _____
- EXERCISE ROUTINE**

- CAFFEINE**
Coffee, cups daily _____
Other _____

CURRENT MEDICATIONS

DRUG ALLERGIES

MEDICAL HISTORY

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> RINGING IN EAR _____ | <input type="checkbox"/> GALL BLADDER TROUBLE _____ | <input type="checkbox"/> TREMOR/HANDS SHAKING _____ | <input type="checkbox"/> MEASLES <input type="checkbox"/> RUBELLA <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> EAR INFECTIONS - FREQUENT _____ | <input type="checkbox"/> JAUNDICE/HEPATITIS _____ | <input type="checkbox"/> MUSCLE WEAKNESS _____ | <input type="checkbox"/> SCARLET FEVER <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> HERPES |
| <input type="checkbox"/> DIZZINESS/FAINTING _____ | <input type="checkbox"/> CHANGE IN BOWEL HABITS _____ | <input type="checkbox"/> NUMBNESS/TINGLING SENSATIONS _____ | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> FAILING VISION _____ | <input type="checkbox"/> DIARRHEA <input type="checkbox"/> CONSTIPATION _____ | <input type="checkbox"/> HEADACHES - FREQUENT _____ | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> EYE INFECTIONS _____ | <input type="checkbox"/> DIVERTICULOSIS <input type="checkbox"/> CROHN'S/COLITIS _____ | <input type="checkbox"/> ARTHRITIS/RHEUMATISM _____ | Females - Please Complete |
| <input type="checkbox"/> NOSE BLEEDS _____ | <input type="checkbox"/> BLOODY OR TARRY STOOLS _____ | <input type="checkbox"/> OSTEOPOROSIS _____ | PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> SINUS TROUBLE _____ | <input type="checkbox"/> HEMORRHOIDS _____ | <input type="checkbox"/> BACK PAIN - RECURRENT _____ | PLANNING PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> SORE THROATS - FREQUENT _____ | <input type="checkbox"/> HERNIA _____ | <input type="checkbox"/> BONE FRACTURE/JOINT INJURY _____ | Menstrual Flow: |
| <input type="checkbox"/> HAYFEVER/ALLERGIES _____ | <input type="checkbox"/> URINE INFECTIONS - FREQUENT _____ | <input type="checkbox"/> GOUT _____ | <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Pain/Cramps |
| <input type="checkbox"/> PNEUMONIA _____ | <input type="checkbox"/> BLOOD IN URINE _____ | <input type="checkbox"/> FOOT PAIN <input type="checkbox"/> COLD NUMB FEET _____ | ____ Days of Flow ____ Length of Cycle |
| <input type="checkbox"/> BRONCHITIS/CHRONIC COUGH _____ | URINATION- <input type="checkbox"/> OVERNIGHT > THAN TWICE | <input type="checkbox"/> RASHES <input type="checkbox"/> HIVES _____ | Date-1st day of last period _____ |
| <input type="checkbox"/> ASTHMA/WHEEZING _____ | <input type="checkbox"/> PAINFUL <input type="checkbox"/> LOSS OF CONTROL | <input type="checkbox"/> PSORIASIS <input type="checkbox"/> ECZEMA _____ | <input type="checkbox"/> Pain/Bleeding during or after sex |
| <input type="checkbox"/> CHEST PAIN _____ | <input type="checkbox"/> DECREASE IN FORCE/FLOW | <input type="checkbox"/> NERVOUSNESS <input type="checkbox"/> DEPRESSION _____ | Number of: |
| <input type="checkbox"/> HIGH BLOOD PRESSURE _____ | <input type="checkbox"/> KIDNEY STONES _____ | <input type="checkbox"/> MEMORY LOSS _____ | ____ Pregnancies ____ Abortions |
| <input type="checkbox"/> HEART MURMUR _____ | <input type="checkbox"/> VENEREAL DISEASE _____ | <input type="checkbox"/> MOODINESS - EXCESSIVE _____ | ____ Miscarriages ____ Live Births |
| <input type="checkbox"/> SWOLLEN ANKLES _____ | <input type="checkbox"/> URETHRAL DISCHARGE _____ | <input type="checkbox"/> PHOBIAS _____ | Birth Control Method _____ |
| <input type="checkbox"/> LEG PAIN - WALKING _____ | <input type="checkbox"/> CHRONIC FATIGUE _____ | <input type="checkbox"/> MENTAL ILLNESS _____ | B.C. Pill (Name) _____ |
| <input type="checkbox"/> VARICOSE VEINS/PHLEBITIS _____ | <input type="checkbox"/> WEIGHT LOSS - RECENT _____ | <input type="checkbox"/> LACTOSE INTOLERANCE _____ | <input type="checkbox"/> Flushing/Menopause |
| <input type="checkbox"/> LOSS OF APPETITE _____ | <input type="checkbox"/> ANEMIA <input type="checkbox"/> BRUISE EASILY _____ | <input type="checkbox"/> PROSTATE DISEASE _____ | Date of Last PAP Test _____ |
| <input type="checkbox"/> DIFFICULTY SWALLOWING _____ | <input type="checkbox"/> CANCER _____ | <input type="checkbox"/> SEXUAL/MENSTRUAL DYSFUNCTION _____ | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> INDIGESTION OR HEARTBURN _____ | <input type="checkbox"/> DIABETES _____ | <input type="checkbox"/> FREQUENT INFECTIONS _____ | Date of Last Mammogram _____ |
| <input type="checkbox"/> PERSISTENT NAUSEA/VOMITING _____ | <input type="checkbox"/> THYROID DISEASE _____ | <input type="checkbox"/> DIPHTHERIA _____ | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> PEPTIC ULCERS _____ | <input type="checkbox"/> CONVULSIONS/SEIZURES _____ | <input type="checkbox"/> TETANUS _____ | |
| <input type="checkbox"/> ABDOMINAL PAIN - CHRONIC _____ | <input type="checkbox"/> STROKE _____ | <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> POLIO <input type="checkbox"/> MUMPS <input type="checkbox"/> | |

EMERGENCY NOTIFICATION

NAME _____
ADDRESS _____ CITY/ZIP _____ TELEPHONE _____