CONFIDENTIAL HEALTH INFORMATION

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.

Wiley Chiropractic Group, P.C.
Terry L. Wiley, DC, CME
511 Main St., Suite #6
Alamosa, Colorado 81101
Phone: (719) 589-5163
Fax: (719) 589-8988
E-Mail: wileychiro@yahoo.com

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 ○ Single ○ Divorced ○ Widowed ○ Separated | Ethnicity

City | State/Province | ZIP/Postal Code | 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 ○ Work Phone ○ Email

Primary Care Provider's Name

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?)

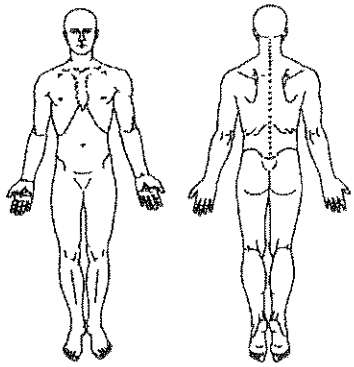
◯ Constant ◯ Comes and goes. How Often? _____

_____

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. Wiley 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.

a. Musculoskeletal

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE ◯
◯ ◯ Osteoporosis	◯ ◯ Arthritis	◯ ◯ Scoliosis	◯ ◯ Neck pain	◯ ◯ Back problems	◯ ◯ Hip disorders	
◯ ◯ Knee injuries	◯ ◯ Foot/ankle pain	◯ ◯ Shoulder problems	◯ ◯ Elbow/wrist pain	◯ ◯ TMJ issues	◯ ◯ Poor posture	Initials ____

b. Neurological

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE ◯
◯ ◯ Anxiety	◯ ◯ Depression	◯ ◯ Headache	◯ ◯ Dizziness	◯ ◯ Pins and needles	◯ ◯ Numbness	Initials ____

c. Cardiovascular

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE ◯
◯ ◯ High blood pressure	◯ ◯ Low blood pressure	◯ ◯ High cholesterol	◯ ◯ Poor circulation	◯ ◯ Angina	◯ ◯ Excessive bruising	Initials ____

d. Respiratory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE ◯
◯ ◯ Asthma	◯ ◯ Apnea	◯ ◯ Emphysema	◯ ◯ Hay fever	◯ ◯ Shortness of breath	◯ ◯ Pneumonia	Initials ____

e. Digestive

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE ◯
◯ ◯ Anorexia/bulimia	◯ ◯ Ulcer	◯ ◯ Food sensitivities	◯ ◯ Heartburn	◯ ◯ Constipation	◯ ◯ Diarrhea	Initials ____

f. Sensory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE ◯
◯ ◯ Blurred vision	◯ ◯ Ringing in ears	◯ ◯ Hearing loss	◯ ◯ Chronic ear infection	◯ ◯ Loss of smell	◯ ◯ Loss of taste	Initials ____

g. Skin

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE ◯
◯ ◯ Skin cancer	◯ ◯ Psoriasis	◯ ◯ Eczema	◯ ◯ Acne	◯ ◯ Hair loss	◯ ◯ Rash	Initials ____

Patient name _____

Patient Number (office use only) _____

Consultation Notes

Doctor's Initials _____

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(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○ ○	Low energy	Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○ ○	PMS symptoms	Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○ ○	Weakness	Initials ____

○ All other systems negative

Patient name _____

Patient Number (office use only) _____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

17. Allergies

Are you allergic to any medications?

Yes ○ No ○ If Yes please list: _____

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine: _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): _____

18. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

FAMILY

19. Family History

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

Relative	Age (If living)	State of health: Good	State of health: Poor	Illnesses	Age at death	Cause of death: Natural	Cause of death: Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
		○	○			○	○

20. Are there any other hereditary health issues that you know about? _____

SOCIAL

21. Social History

Tell Dr. Wiley about your health habits and stress levels.

Alcohol use	○ Daily	○ Weekly	How much? _____
Coffee use	○ Daily	○ Weekly	How much? _____
Tobacco use	○ Daily	○ Weekly	How much? _____
Exercising	○ Daily	○ Weekly	How much? _____
Pain relievers	○ Daily	○ Weekly	How much? _____
Soft drinks	○ Daily	○ Weekly	How much? _____
Water intake	○ Daily	○ Weekly	How much? _____

Hobbies: _____

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

Doctor's Initials _____

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22. 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	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

23. What is the major stressor in your life? _____

24. How much sleep do you average per night? _____ **Hours**

25. What is the type and approximate age of your mattress and pillow? _____

26. What is your preferred sleeping position? _____

27. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

28. What would be the most significant thing that you could do to improve your health? _____

29. 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: _____

_____ Signature

_____ Date (MM/DD/YYYY)

Consultation Notes

Patient name

Patient Number
(office use only)

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