Curry Chiropractic
John Curry DC, MS
13936 State Highway 97 Petersburg, IL 62675

CONFIDENTIAL HEALTH INFORMATION

All information you supply is confidential.
We comply with all federal privacy standards.
(Please Print Clearly)

Name:_____ **Gender: M F**

Mailing Address:_____

City_____**State**_____**Zip Code**_____

Birth Date:_____/____/_____**Age:**_____

Marital Status:____**Single**_____**Married**_____**Separated**____**Divorced**_____**Widowed**_____**Partnered**

	May We Leave A Message?	**Preferred method of contact?**
Home Phone #:_____	**Yes No**	**___Home Phone ___Cell Phone**
Cell Phone #: _____	**Yes No**	**___Work Phone**

Work Phone #: _____ **Yes No** **Employer:**_____

E-Mail:_____ **Yes No** **Occupation:**_____

Emergency contact:_____

Relation to pt:_____**Phone** _____

Primary Care Dr:_____

Whom may we thank for referring you to us?_____

Is there anyone you would like us to share your clinical Information with? ___NO_____YES

Names:_____

Is today's visit due to an auto accident or work-related injury? ___YES ___NO

If YES, please tell receptionist before completing paperwork

Do you have Medicare coverage? ___YES ___NO

If YES, we will need to copy your Medicare Cards & photo ID before you see the Dr.

Who is responsible for payment?_____**Relationship to patient?** _____

Address:_____**Phone:** _____

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment, or Prevention of Disease." A vitamin is not a drug. Neither is a mineral, a trace element, an amino acid, an herb, or homeopathic remedy. Although a vitamin, a mineral, a trace element, an amino acid, an herb, or a homeopathic remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Signature of patient/guardian **Date (MM/DD/YYY)**

Patient Name:_____ **DOB:**_____ **Date:**_____

1. Please list top 3 symptoms/concerns:

*1)*_____

*2)*_____

*3)*_____

2. And are the result of:____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(On a 10 point scale with zero being no pain, and 10 being agonizing pain, how extreme are your current symptoms?) _____

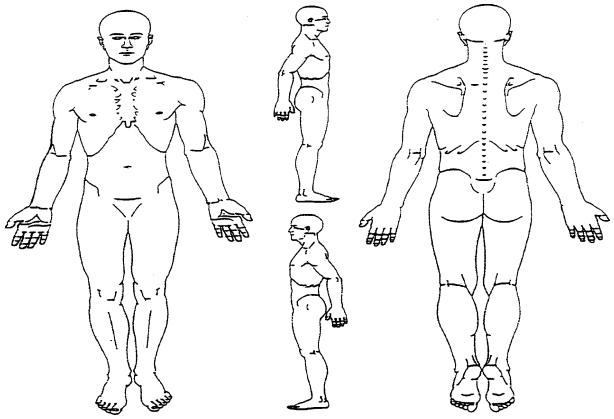
5. Duration & Timing (When did it start and how often do you feel it?) ___ *Constant* ___ *Comes and goes How often?*_____

6. Quality of symptoms (What does it feel like?)

___*Numbness* _*Tingling* _*Stiffness* _*Dull* _*Aching* _*Cramps*

___*Nagging* _*Sharp* _*Burning* _*Shooting* _*Throbbing* _*Stabbing* _*Other* _____

7. Where does it hurt? Mark the area(s) on the pictures below. "O" for current conditions. "X" for past conditions.



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

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9. Aggravation 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* _*Over-the-counter drugs* _*Homeopathic remedies* _*Physical therapy* _*Surgery*

___*Chiropractic* ___*Acupuncture* ___*Massage* ___*Ice* ___*Heat* ___*Other* _____

*11. What else should the Dr. know about your current condition?*_____

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12. How does your current condition interfere with your:

*Work or career:*_____

*Recreational activities:*_____

*Household responsibilities:*_____

*Personal relationships:*_____

Patient Name:_____ **DOB:**_____ **Date:**_____

13. Review of Systems

Using the point scale, rate each of the following symptoms based upon your typical health profile for the past 30 days:

Point Scale: *0 -* ***Never*** *or* ***almost never*** *have the symptom*
1 - ***Occasionally*** *have it, effect is* ***not severe*** *3 -* ***Frequently*** *have it, effect is* ***not severe***
2 - ***Occasionally*** *have it, effect is* ***severe*** *4 -* ***Frequently*** *have it, effect is* ***severe***

HEAD ___Headaches
___Faintness
___Dizziness
___Insomnia **Total**_____

EYES ___Watery or itchy eyes
___Swollen, reddened or sticky eyelids
___Bags or dark circles under eyes
___Blurred or tunnel vision
(does not include near/far-sightedness) **Total**_____

EARS ___Itchy ears
___Earaches/infections
___Drainage from ear
___Ringing in ears, hearing loss **Total**_____

NOSE ___Stuffy nose
___Sinus problems
___Hay fever
___Sneezing attacks
___Excessive mucus formation **Total**_____

MOUTH/ THROAT ___Chronic coughing
___Gagging, frequent need to clear throat
___Sore throat, hoarseness, loss of voice
___Swollen or discolored tongue, gums, lips
___Canker sores **Total**_____

SKIN ___Acne
___Hives, rashes, dry skin
___Hair loss
___Flushing, hot flashes
___Excessive sweating **Total**_____

HEART ___Irregular or skipped heartbeat
___Rapid or pounding heartbeat
___Chest pain **Total**_____

LUNGS ___Chest congestion
___Asthma, bronchitis
___Shortness of breath
___Difficulty breathing **Total**_____

OTHER ___Frequent or urgent urination
___Genital itch or discharge
___Frequent illness **Total**_____

Digestive Tract _____ Nausea,vomiting
___Diarrhea
___Constipation
___Bloating
___Belching, passing gas
___Intestinal/stomach pain
___Heartburn **Total**_____

Joints/Muscles _____ Pain or aches in muscles
___Feeling of weakness/tiredness
___Stiffness or limitations of movement
___Pain or aches in joints
___Arthritis **Total**_____

WEIGHT _____ Binge eating/drinking
___Craving certain foods
___Excessive weight
___Compulsive eating
___Water retention
___Underweight **Total**_____

ENERGY/ACTIVITY _____ Fatigue,sluggishness
___Apathy, lethargy
___Hyperactivity
___Restlessness **Total**_____

MIND _____ Poor memory
___Confusion,poor comprehension
___Poor concentration
___Difficulty in making decisions
___Stuttering or stammering
___Slurred speech
___Learning disabilities **Total**_____

EMOTIONS _____ Mood swings
___Anxiety,fear,nervousness
___Anger, irritability, aggressiveness
___Depression **Total**_____

GRAND TOTAL _____

Patient Name:_____ **DOB:**_____ **Date:**_____

14. Your Medical History:

All known allergies:_____

Current medications:_____

Illnesses:_____

Surgeries:_____

Hospitalizations:_____

Family History

Do you have a family history of: ___Diabetes ___Cancer ___Heart Disease ___High Blood Pressure

___Stroke ___Coronary Artery Disease ___Thyroid Disease ___Rheumatoid Arthritis

Other_____

15. Social History

Marital Status: __Single _Married _Partnered _Separated _Divorced _Widowed

Use of Alcohol: ___Never ___No longer use ___History of alcohol abuse

Current Use - Type_____ ___Rare ___Occasional ___Moderate ___Daily

Use of Tobacco: ___Never ___Quit – how long ago?_____ **___Smoke**_____**packs/day for**_____**years**

Do others depend upon you for their care? ____Children–age(s)_____ Pet(s)–what kind? _____

_____ Elderly or disabled family member Other _____

Exercise: ___Never ___Rare ___Occasional ___Weekly ___Several times a week ___Daily

Types of exercise: _____

How much sleep do you average per night? _____hours

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

Acknowledgements

To set clear expectations, improve communication 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 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 on my behalf for seeking reimbursement from any involved third parties.**

Initials_____ **I grant permission to be called to confirm or reschedule an appointment.**

Initials_____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I will be asked to pay today for services and supplies received. I give permission to release information to my insurance company if requested.**

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 of patient/guardian Date (MM/DD/YYY)