Camp Wisdom
BACK & NECK
CARE CENTER

Pain Relief from Caring Professionals

CONFIDENTIAL PATIENT INFORMATION

DATE_____

NAME_____AGE_____BIRTH DATE_____
ADDRESS_____CITY_____ZIP_____
HOME PHONE_____CELL PHONE_____
SOCIAL SECURITY# _____SEX: M F
E-MAIL_____MARITALSTATUS: S M D W
OCCUPATION_____ FULL TIME_____ PART TIME_____
EMPLOYER_____
ADDRESS_____CITY_____ZIP_____
WORK PHONE_____
HOW DID YOU HEAR ABOUT THIS CLINIC?_____
PURPOSE OF THIS APPOINTMENT: _____
HOW LONG HAVE YOU HAD THIS COMPLAINT? _____
OTHER DOCTORS SEEN FOR THIS CONDITION: _____
HAVE YOU BEEN TREATED? YES_____NO_____DESCRIBE:_____
WHAT MEDICATIONS ARE YOU TAKING? _____
_____
TYPE OF INJURY: WORK_____ AUTO_____ OTHER_____
NEAREST EMERGENCY CONTACT NAME_____
NEAREST CONTACT EMERGENCY PHONE NO._____

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INSURANCE INFORMATION (If applicable)

NAME OF PERSON RESPONSIBLE FOR PAYMENT_____
ARE YOU INSURED? YES____NO____
POLICY HOLDER_____POLICY #_____
INSURANCE COMPANY_____PHONE #_____
INSURANCE ADDRESS_____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ALL CHARGES NOT PAID BY MY INSURANCE CARRIER.

I AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT TO CAMP WISDOM BACK AND NECK CARE CENTER.

PATIENT'S SIGNATURE_____DATE_____

GUARDIAN SIGNATURE AUTHORIZING CARE_____

REVIEW OF SYSTEMS

Name:_____ Date: _____

Please enter: **1 = previously 2 = presently** in front of the following signs and symptoms.

GENERAL SYMPTOMS
___ Headache
___ Fever
___ Chills
___ Night Sweats
___ Fainting
___ Dizziness
___ Convulsions
___ Loss of Sleep
___ Fatigue
___ Nervousness
___ Loss of Weight
___ Numbness or Pain in Arms/legs/hands
___ Allergy (what)
___ Wheezing
___ Neuralgia

GASTRO-INTESTINAL
___ Poor Appetite
___ Poor Digestion
___ Excessive Hunger
___ Belching or Gas
___ Nausea
___ Vomiting
___ Vomiting Blood
___ Pain over Stomach
___ Constipation
___ Diarrhea
___ Colon Trouble
___ Hemorrhoids (Piles)
___ Liver Trouble Jaundice
___ Gall Bladder Trouble

EYE EAR NOSE THROAT
___ Poor Vision
___ Crossed Eyes
___ Pain in Eyes
___ Deafness
___ Earaches
___ Ear Noises
___ Ear Discharges
___ Nasal Obstruction
___ Nose Bleeds
___ Sore Throat
___ Hoarseness
___ Hay Fever
___ Asthma
___ Frequent Colds
___ Enlarged Thyroid Tonsillitis
___ Sinus Trouble

RESPIRATORY
___Chronic Cough
___ Spitting Blood
___ Chest Pain
___ Difficulty Breathing
___ Asthma

GENITO-URINARY
___ Frequent Urination
___ Painful Urination
___ Blood in Urine
___ Kidney infection
___ Bed Wetting
___ Inability to control Urine
___Prostate Trouble

MUSCLES & JOINTS
___ Joint Pain
___ Arm/Leg Numbness
___ Neck Pain
___Back Pain
___ Swollen Joints
___ Foot Trouble
___ Painful Tailbone
___ Pain between Shoulder
___ Headache
___ Spinal Curvature

CARDIO-VASCULAR
___ Rapid Heart
___ Slow Heart
___High Blood Pressure
___ Low Blood Pressure
___ Pain Over Heart
___ Previous Heart Trouble
___ Poor Circulation
___Varicose Veins
___ Strokes

SKIN OR ALLERGIES
___ Skin Eruptions
___ Itching
___ Bruising Easily
___ Dryness
___ Boils
___ Sensitive Skin
___ Hives or Allergy
___Eczema
___ Medicines

FOR WOMEN ONLY
___ Painful Periods
___ Excessive Flow
___ Irregular Cycles
___ Hot Flashes
___ Cramps or Backache
___ Miscarriage
___ Vaginal Discharge
___ Pregnant (presently)
___ Last Pap _____
___ Regular
___ MENOPAUSE

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	O	O	O	O	O
Father	O	O	O	O	O
Brother # of___	O	O	O	O	O
Sister # of ___	O	O	O	O	O

EXERCISE
___ None
___ Moderate
___ Daily

HABITS
___ Smoke pack(s)/day ___
___ Drink alcohol ___ day/week

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?
___ Appendicitis
___ Mumps
___ Pleurisy
___ Eczema
___ Pneumonia
___ Anemia
___ Influenza
___ Lumbago
___ Whooping Cough
___ Measles
___ Heart Disease
___ Mental Disorder
___ Tuberculosis
___ Cancer
___ Goiter
___ Epilepsy
___ Polio
___ Diabetes
___ Venereal Infection
___Rheumatic Fever
___ Chicken Pox
___ Alcoholism
___ Arthritis

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CAMP WISDOM BACK &
NECK CARE CENTER
MICHAE W.HOWE, D.C.

Past Health History

PATIENT NAME:

Do you have any of the following? Please check YES or NO for each condition.

Relative Contraindications:

Articular Hypermobility Disease	☐ Yes ☐ No
Severe Demineralization of Bone	☐ Yes ☐ No
Benign Bone Tumor (Spine)	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No
Are You Taking Anticoagulants Therapy	☐ Yes ☐ No
Radiculopathy with Progressive Neurological Signs, Radiating Pain, Numbness or Weakness into:	
☐ Upper Extremities	☐ Yes ☐ No
☐ Lower Extremities	☐ Yes ☐ No

Absolute Contraindications:

Rheumatoid Arthritis	☐ Yes ☐ No
Ankylosing Spondylitis	☐ Yes ☐ No
Fracture(s)_____	☐ Yes ☐ No
Dislocation(s)_____	☐ Yes ☐ No
Unstable OS Odontoedum	☐ Yes ☐ No
Malignancies	☐ Yes ☐ No
Infection of bones or joints of the vertebral column	☐ Yes ☐ No
Myelopathy	☐ Yes ☐ No
Cauda Equina Syndrome	☐ Yes ☐ No
Vertebrobasilar Insufficiency Syndrome	☐ Yes ☐ No
Major Artery Aneurysm	☐ Yes ☐ No

Previous Major Illnesses and Injuries_____

Operations, Hospitalizations, Surgeries_____

Medications you are currently taking: ☐ None

☐ High Blood Pressure_____ ☐ Cholesterol_____ ☐ Pain_____ ☐ Arthritis_____

☐ Depression_____ ☐ Anxiety_____ ☐ ADD/ADHD_____ ☐ Insulin_____

☐ Other_____

Allergies

Supplements

Family History - Immediate Family Members (Father, Mother, Brother, Sister)

Health status of family members:_____

Are there any family members that suffer from:

☐ Stroke ☐ Heart Disease ☐ Cancer ☐ Tumor ☐ Degenerative Disc Disease ☐ Arthritis ☐ Osteoporosis

☐ Other_____

If any of the above items are checked, then whom in your family suffers?_____

Are there any diseases that are "hereditary" or seem to run in your family?

Social History - Please answer the following:

Please tell the Doctor about your activities:

Exercise:	Work / School:	Habits: ☐ None	Education:
☐ None	☐ Sitting	☐ Smoking - Packs Per Day____ ☐ None Drugs_____ ☐ None	☐ High School
☐ Occasional	☐ Standing	☐ Alcohol - Times Per Week_____ ☐ None	☐ Some College
☐ Daily	☐ Light Labor	☐ Caffeine: Coffee, Tea, Sodas... Cups Per Day _____ ☐ None	☐ College Grad
☐ Weekly	☐ Heavy Labor	Hobbies_____ ☐ None	☐ Post Grad
☐ Other	☐ Computer		

I certify the information on these forms are true to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic and therapeutic care for my condition if I am accepted as a patient.

Patient Signature_____ Date ___/___/___

Doctor's Signature_____ Date ___/___/___