Midwest Health Center, P.C.

Name____S.S._____________________________

Address____

City_______________________State____________________Zip_______________________

Male________Female________Marital Status_____________Birthdate___________________

Home Phone________________________Mobile Phone_______________________________

Email Address____

Employer__________________________________Occupation__________________________

Emergency Contact___________________Phone_________________Relation_____________

Name of local primary physician_________________________May we contact them?________

Whom may we thank for referring you to us?____

Race

White Black/African American Hispanic Other_____________ I choose not specify

Preferred Language

English Spanish American Sign Language Other___________ I choose not to specify

Ethnicity

Not Hispanic or Latino Hispanic or Latino I choose not to specify

Verification Question

What is the name of your favorite pet? In what city were you born? What high school did you attend?

What is your favorite movie? What is your mother's maiden name? On what street did you grow up on?

What was the make of you first car? When is you anniversary?

Verification Answer to the Chosen Question____

***Must be at least SIX characters**

Symptoms

Main Complaint________________________When did it start?__________________________

Getting Worse?_____Getting Better?________How often does it bother you?______________

What activity bothers it the most?____

When is at its best?_______________________When is it at its worse?___________________

Rate the pain (Zero being pain free 10 being unbaerable pain) 1 2 3 4 5 6 7 8 9 10

Other Chiropractors?_______________________Positive Experience?____________________

Other type of physician/therapist?___________________Positive Experience?______________

Health History (please circle all that apply)

Aids/HIV Allergy Shots Anemia Anorexia Appendicitis Fibromyalgia Mumps M.S. Liver Disease Herniated Disc

Measles Migraines Stroke Ulcers Kidney Disease Parkinson's Pacemaker Pneumonia Prosthesis Thyroid Disease

Arthritis Allergies Fatigue Tuberculosis Depression High Cholesterol Hypertension Diabetes I or II Asthma Bleeding

Cancer Cataracts Chicken Pox Osteoporosis Epilepsy Fractures Glaucoma Goiter Heart Disease Hepatitis Hernia

Family History	Age	Health (Well, Fair, Poor)	Age of death	Health Problems (Diabetes, Cancer, High Blood Pressure, etc.)
Father				
Mother				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Son/Daughter				
Son/Daughter				
Son/Daughter				
Son/Daughter				

Previous Surgeries and Dates____

____

List Medications you are currently taking and the dose

____

____

____

List any allergies you have had to medications____

____

What kind of exercise do you do?____

Do you consume Alcohol? (Circle One) Never Occasionally Often

Do you currently smoke tobacco of any kind? Yes Former Never

If yes, how often do you smoke? Every day Or Sometimes

If yes, what is your level of interest in quitting smoking?

1 2 3 4 5 6 7 8 9 10

Have you had an x-ray, CT scan, or MRI of your low back spine in the past 28 days? Yes___No__

**All above questions have been answered accurately and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed to this office.

Patient Signature____Date____________________