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.

Jason Queiros, DC
John Dinneen, DC
4 Armstrong Rd
Shelton, CT 06484
(203) 8428631
www.SheltonSportsandSpine.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

Patient Number (office use only)

Whom may we thank for referring you?

○ No ○ Yes

When?

If so, whom?

Age

Gender
○ Male ○ Female

Race
○ American Indian ○ Alaskan Native ○ Asian ○ Black/African American
○ Native Hawaiian/ Pacific Islander ○ Other ○ White
○ Decline to answer

Ethnicity
○ Hispanic or Latino
○ Not Hispanic or Latino
○ Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over)
○ Never A Smoker ○ Former Smoker
○ Current Every Day Smoker ○ Current Some Day Smoker
○ Heavy Smoker ○ Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status ○ Married
○ Single ○ Divorced
○ Widowed ○ Separated

City

State/Province

ZIP/Postal Code

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name (Age)

Emergency Contact

Emergency Contact's Phone

Your Occupation

Your Employer

Work Phone

Address

City

State/Province

ZIP/Postal Code

Primary Care Provider's Name

Preferred method of contact?
○ Cell Phone ○ Text Message
○ Work Phone ○ Email

Insurance Carrier

Policy and Group Numbers

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: ____________________

And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other __________

Grade the pain on a 0-10 scale ____ /10

Describe the pain: dull, achy, tight, stiffness, sharp, shooting, stabbing, throbbing, spasms, instability, numbness, tingling, burning

Onset (When did you first notice your current symptoms?) ____________________

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Overthecounter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other ____________________

Secondary Complaint
The secondary symptom that prompted me to seek care today is: ____________________

And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other __________

Grade the pain on a 0-10 scale /10

Describe the pain: dull, achy, tight, stiffness, sharp, shooting, stabbing, throbbing, spasms, instability, numbness, tingling, burning

Onset (When did you first notice your current symptoms?) ____________________

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Overthecounter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other ____________________

Additional Complaint
The additional symptom that prompted me to seek care today is: ____________________

And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other __________

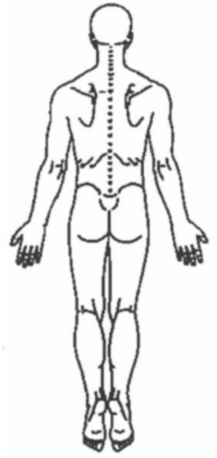
Grade the pain on a 0-10 scale /10

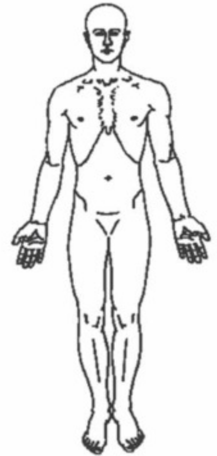
Describe the pain: dull, achy, tight, stiffness, sharp, shooting, stabbing, throbbing, spasms, instability, numbness, tingling, burning

Onset (When did you first notice your current symptoms?) ____________________

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Overthecounter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other ____________________

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past





1. What else should the doctors know about your current condition? ____________________

2. How does your current condition interfere with your:

Work or career: ____________________

Recreational activities: ____________________

Household responsibilities: ____________________

Personal relationships: ____________________

3. 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	
◯ ◯ Osteoporosis	◯ ◯ Arthritis	◯ ◯ Scoliosis	◯ ◯ Neck pain	◯ ◯ Back problems	◯ ◯ Hip disorders	NONE ◯
◯ ◯ 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	
◯ ◯ Anxiety	◯ ◯ Depression	◯ ◯ Headache	◯ ◯ Dizziness	◯ ◯ Pins and needles	◯ ◯ Numbness	NONE ◯ Initials ____

c. Cardiovascular

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

d. Respiratory

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

e. Digestive

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

f. Sensory

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

g. Skin

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

____
Patient name

____
Patient Number
(office use only)

____
Doctor's Initials

(Continued from previous page)

h. Endocrine

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

i. Genitourinary

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

j. Constitutional

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

Patient name ____________

Patient Number (office use only) ____________

○ All other systems negative

Past Personal, Family and Social History

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

PERSONAL

4. 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			

7. Allergies

Are you allergic to any medications?

Yes ○ No ○ If Yes please list: ____________

5. 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: ____________

6. 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, overthecounter, natural supplements, enzymes, vitamins and minerals): ____________

8. 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

9. Family History

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

FAMILY

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	____	○	○			○	○
		○	○			○	○

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

____

11. Social History

Tell the doctors about your health habits and stress levels.

SOCIAL

Alcohol use	Daily	Weekly	How much? ____________
Tobacco use	Daily	Weekly	How much? ____________
Exercising	Daily	Weekly	How much / type? ____________
Pain relievers	Daily	Weekly	How much / type? ____________
Rec. Drug use	Daily	Weekly	How much / type ____________
Soft drinks	Daily	Weekly	How much? ____________
Water intake	Daily	Weekly	How much? ____________

Hobbies: ____________

Are you interested in any of the following?

Diet / Weight Loss	Yes ○	No ○
Acupuncture ?	Yes ○	No ○

Doctor's Initials ____________

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12. 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	◯	◯	◯	◯
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering or bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love life	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Exercising	◯	◯	◯	◯
Yard work	◯	◯	◯	◯

Patient name

Patient Number
(office use only)

13. What is the major stressor in your life?___________________________

14. How much sleep do you average per night?_______**Hours**

15. What is the type and approximate age of your mattress and pillow?________

16. What is your preferred sleeping position? ______________

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

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

____

19. In addition to the main reason for your visit today, what additional health goals do you have? ______________________

____

Consultation Notes

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 Xray 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 noncovered 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.**

Doctor's Initials

______________________________ ______________________
Patient (or Guardian's) signature Date (MM/DD/YYYY)

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