

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State/Prov: _____ Zip/Postal Code: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: ___M ___F

Cell Phone: _____ E-mail Address: _____

Social Security # _____ Driver's License # _____

Circle One: Single Married Widowed Divorced Separated Other _____

Business Employer _____

Business Phone: _____ Type of Work _____

Name of Spouse _____ Spouse's Social Security # _____

Spouse's Employer _____ Business Phone _____

Referred to this office by: _____ Relationship _____

Who is responsible for your bill, You and ___ Spouse ___ Worker's Comp ___ Auto Ins. ___ Medicare ___ Medicaid

CURRENT HEALTH CONDITION

Unwanted Health Condition _____

Other Doctors seen for this condition ___ Yes ___ No Who? _____

Type of Treatment: _____ Results _____

When did this condition begin? _____ Has this occurred before ___ Yes ___ No

Is Condition: ___ Job Related ___ Auto Accident ___ Home Injury ___ Fall ___ Other: _____

Date of Accident: _____ Time of Accident _____

Have you made a report of your accident to your Employer: ___ Yes ___ No

Drugs you now take: _____ Nerve Pills ___ Pain Killers/Muscle Relaxers ___ Blood Pressure ___ Insulin

___ Other _____

Do you wear a Shoe Lift? ___ Yes ___ No

Do you suffer from any condition other than that which you are now consulting us? _____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ___ Appendectomy ___ Tonsillectomy ___ Gall Bladder ___ Hernia ___ Back Surgery

___ Broken Bones ___ Other: _____

Major Accident or Falls: _____

Hospitalization (Other than Above): _____

Previous Chiropractic Care: ___ None ___ Doctor's Name & Approximate Date of Last Visit _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YO HAVE HAD:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |

INTAKE

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

FEMALES ONLY:

When was your last period? _____

Are you pregnant?
 Yes No Not Sure

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problem/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems

FAMILY HISTORY

The following members have a Same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and my-self. Furthermore, I understand that Ryan Family Chiropractic, Inc. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Ryan Family Chiropractic, Inc. will be credited to my account on receipt. However, I clearly understand and agree that all services provided to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services provided to me will be immediately due and payable.

I hereby authorize Dr. Jason Ryan to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid to Dr. Jason Ryan , for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature: _____ Date: _____

Consent to Treat a Minor: _____ Date: _____

Guardian or Spouse's
Signature of Authorizing Care: _____ Date: _____