DATE	ID. NO

CONFIDENTIAL PERSONAL HISTORY

Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Birth date: _____ Age: ____ Sex: ☐ M ☐ F Phone: _____ Cell: _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Business/Employer:_____ Type of Work: _____
Business Phone #: _____ Email Address: _____
Name of Spouse: _____ Names and ages of Children: _____
Spouse's Employer: _____ Business Phone : _____
Type of Work: _____
Who referred you to Dr. Spearman: _____
Name/Phone # of Emergency Contact: _____ Relationship: _____
Who is responsible for your bill? ☐ You ☐ Spouse ☐ Workers Comp ☐ Auto Ins. ☐ Medicare ☐ Medicaid
☐ Personal Health Insurance (Name): _____ INSURANCE CARD #: _____
☐ Medicare #: _____

CURRENT HEALTH CONDITION

Reason for this appointment: _____
Other Doctors Seen For This Condition? ☐ Yes ☐ No Name: _____
Type of Treatment: _____ Results? _____
When did this condition begin? _____ Has this condition occurred before? ☐ Yes ☐ No
Is this condition ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other _____
Date of Accident: _____ Time of Accident _____
Have you informed your employer of the accident? ☐ Yes ☐ No
Are you taking any medication? ☐ Yes ☐ No If yes, what type? ☐ Nerve Pills ☐ Painkillers /Muscle Relaxers
☐ Blood Pressure Medications ☐ Insulin ☐ Other _____
Do you wear a shoe lift? ☐ Yes ☐ No
Do you have any other complaints than those mentioned above, such as knee pain, sciatica, plantar fasciitis, carpal tunnel syndrome, etc.)

_____

__ _____

PAST HEALTH HISTORY

Major Surgeries/Operations: ☐ Appendectomy ☐ Back Surgery ☐ Broken Bones ☐ Gall Bladder ☐ Hernia
☐ Tonsillectomy ☐ Other _____
Major Accidents, Auto Accidents or Falls: _____

_____

Hospitalizations (Other than the above): _____
Previous Chiropractic Care? ☐ None ☐ Doctor's Name & Approximate Date of Last Visit

Health history is extremely important in predicting the kind of chiropractic care you will need.

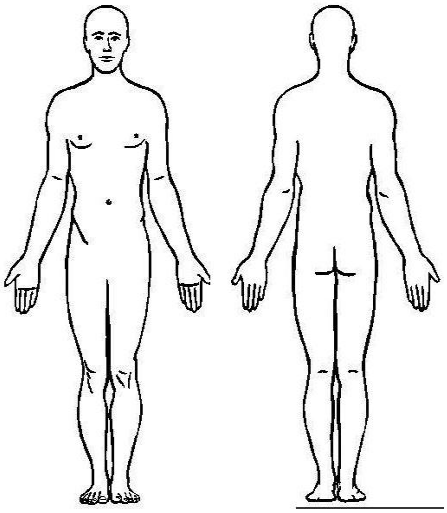
CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING DISEASES:

☐ Pneumonia	☐ Mumps	☐ Influenza	INTAKE PER DAY
☐ Rheumatic fever	☐ Chicken Pox	☐ Pleurisy	☐ Coffee _____
☐ Polio	☐ Small Pox	☐ Arthritis	☐ Tea _____
☐ Tuberculosis	☐ Diabetes	☐ Epilepsy	☐ Alcohol _____
☐ Whooping Cough	☐ Cancer	☐ Mental Disorders	☐ Cigarettes _____
☐ Anemia	☐ Heart Disease	☐ Lumbago	☐ White Sugar _____
☐ Measles	☐ Thyroid	☐ Eczema	

Have you tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD IN THE LAST 6 MONTHS:

☐ Low Back Pain	☐ Gas/Bloating After Meals
☐ Pain Between Shoulders	☐ Heartburn
☐ Neck Pain	☐ Black/Bloody stool
☐ Arm Pain	☐ Colitis/Irritable Bowel Syndrome
☐ Joint Pain/Stiffness	☐ Bladder Problems
☐ Problems Walking	☐ Painful/Excessive Urination
☐ Difficulty Chewing/Clicking Jaw	☐ Discolored Urine
☐ General Stiffness	
☐ Nervousness	☐ Chest Pain
☐ Numbness	☐ Shortness of Breath
☐ Paralysis	☐ Blood Pressure Problems
☐ Dizziness	☐ Irregular Heartbeat
☐ Forgetfulness	☐ Heart Problems
☐ Confusion/Depression	☐ Lung Problems/Congestion
☐ Fainting	☐ Varicose Veins
☐ Convulsions	☐ Swollen Ankles
☐ Cold/Tingling Extremities	☐ Stroke
☐ Overstressed	
☐ Fatigue	☐ Vision Problems
☐ Allergies	☐ Sore Throat
☐ Loss of sleep	☐ Ear Aches
☐ Fever	☐ Difficulty Hearing
☐ Headaches	☐ Clogged Sinuses
☐ Dental Problems	☐ Stuffy Nose
☐ Poor/Excessive Appetite	☐ Abdominal Cramps
☐ Excessive Thirst	☐ Menstrual Irregularity
☐ Frequent Nausea	☐ Menstrual Cramps
☐ Vomiting	☐ Vaginal Pain/Infection
☐ Diarrhea	☐ Breast Pain/Lumps
☐ Constipation	☐ Prostate/Sexual Dysfunction
☐ Hemorrhoids	☐ Other Problems
☐ Liver Problems	☐
☐ Problems With Weight	☐



Please indicate your area(s) of

WOMEN ONLY:

When was your last period? _____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

FAMILY HISTORY:

The following family members have the same or similar problems

☐ Father
☐ Mother
☐ Brother
☐ Sister
☐ Spouse
☐ Child

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

DIAGNOSIS:

PATIENT ACCEPTED? ☐ Yes ☐ No ☐ Deferred Doctor's Signature _____