

Personal History for Korwitts Chiropractic Center

Name: _____ Today's Date: _____

Birth Date: _____ Sex: ___ M ___ F Social Security #: _____

Address: _____ City: _____ State: ___ Zip: _____

Primary Phone : _____ Other Phone: _____

E-mail address: _____ Employer: _____

Occupation: _____ Work Phone: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____

Circle One: Child Married Single Widowed Divorced Separated

REFERRED BY: _____

*** IF CHILD MUST FILL OUT BELOW SECTION ***

Parents Name: _____ Parents Date of Birth: _____

Parents Social Security #: _____ Parents Employer: _____

Who is responsible for your bill? Self Parent Spouse Worker's Comp Medicare Auto Insurance

Current Health Condition

Reason for this visit: _____

Have you seen other doctors for this condition? Yes No Who? _____

Type of treatment: _____ Results: _____

When did this condition begin? _____

Is this condition: Job related Auto accident Home injury Fall Other

Date of accident: _____ Time of accident: _____

Have you reported this accident to your employer? Yes No

Do you take anti-depressants?	YES	NO
Do you take blood pressure medication?	YES	NO
Do you take allergy medication?	YES	NO
Do you take pain killers or muscle relaxants?	YES	NO
Do you require insulin?	YES	NO
Do you use drops for Glaucoma?	YES	NO
Are you taking Ritalin?	YES	NO

Please list any and all prescription drugs you are now taking... list both name and purpose:

Have you had a tonsillectomy?	YES	NO
Have you had an appendectomy?	YES	NO
Have you had gall bladder surgery?	YES	NO
Have you had back surgery?	YES	NO
Have you had hernia surgery?	YES	NO
Have you had a hip or knee replacement?	YES	NO
Have you had cataract or eye surgery?	YES	NO
Have you had broken bones?	YES	NO
Have you had a hysterectomy?	YES	NO
Have you had cosmetic surgery?	YES	NO
Have you had foot surgery?	YES	NO

Describe any major accidents or falls: _____

Describe the purpose of any hospitalizations other than noted above: _____

Have you previously seen a chiropractor? YES NO Name: _____

Date of last visit: _____

How many bowel movements do you have each day? _____

Do you regularly eat breakfast? _____

Drink Coffee? _____ Drink Alcohol? _____ Drink milk? _____

How many glasses of water do you drink each day? _____ Is it filtered water? _____

Do you wear heel lifts or orthotics in your shoes? _____

Are you allergic to any foods? _____

What food or foods do you crave? _____

How often do you have a headache? _____

How many hours do you sleep each night? _____ Do you suffer from insomnia? _____

How old is your mattress? _____ Is there a TV or computer in your bedroom? _____

Do you ever need digestive aids? _____ What kind do you take? _____

Do you smoke? _____ How much per day? _____ Have you ever smoked? _____

Are you on birth control pills? _____ Have you ever had a sexually transmitted disease? _____

Read through the following symptoms/conditions and circle any that apply to you:

- | | | |
|------------------------|-------------------|-----------------------|
| Carpal Tunnel | Weight Problems | Lung Problems |
| Tennis Elbow | Sore Throat | Shortness of Breath |
| Migraine Headaches | Ringing in Ears | Asthma |
| Arm Pain | Ear Pain | Heart Problems |
| Gout | Dental Problems | Stroke |
| Neck Pain | Cancer | ADD |
| Numbness | Lyme's Disease | Irritability |
| Bone Spurs | Fungal Infections | Multiple Sclerosis |
| Joint Stiffness/Pain | Fatigue | Bi-Polar Disorder |
| Paralysis | Eczema | Alcoholism |
| Scoliosis | TMJ | Seizures |
| Forgetfulness | Varicose Veins | Depression |
| Diarrhea | Stress | Dyslexia |
| Menopause | Arthritis | Memory Problems |
| Bladder Trouble | Cataracts | Hearing Problems |
| Menstrual Irregularity | Fever | Hemorrhoids |
| Breast Lumps | Stuffy Nose | Excess Cramping |
| Fertility Problems | Dizziness | Yeast Infections |
| Prostate Troubles | Muscle Cramps | Heartburn |
| Frequent Urinations | Frequent Cold/Flu | PMS |
| Poor Appetite | Cold Extremities | Dairy Allergy |
| Sexual Dysfunctions | Liver Problems | Restless Leg Syndrome |
| Colitis | Thyroid Disorder | Fibroid Tumors |
| Constipations | Drug Addiction | Incontinence |
| Blood in Stool | Swollen Glands | Chronic Fatigue |
| Hormonal Imbalance | Acne | |

If female, when was your last period? _____ Are you pregnant? _____

Have you been tested HIV positive? _____

List any nutritional supplements that you take regularly: _____

Describe your spouse's health: _____

Describe the health of your children: _____

Do you have a preference in the Doctor you see?

____ Dr. Victor T. Korwitts

____ Dr. Melissa Andrews

In assessing your own health, what are your top 5 areas of concern? Please consider conditions, symptoms and difficulties that may not be related to chiropractic care. As an example, you may be setting an appointment at Korwitts Chiropractic Center to deal with chronic neck pain, but your five greatest health concerns are 1) Excess Weight 2) Insomnia 3) Neck Pain 4) Nasal Congestion 5) Moodiness

1) _____

2) _____

3) _____

4) _____

5) _____

What currently causes you the greatest degree of mental/emotional stress in life?

Most patients come to our Center having one of two objectives in mind concerning their healthcare. Some desire symptomatic relief of pain or discomfort only (Relief Care). Others are interested in having the cause or problem as well as the symptoms corrected and relieved (Corrective Care). Your doctor will weigh your needs and desires when recommending your treatment program.

Are you seeking? Relief Care Only Or Corrective Care **CIRCLE ONE**