



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.

Dohnal Chiropractic
6005 Nolensville Pk
Ste 105
Nashville, TN 37211
(615) 781-8181
www.dohnalchiropractic.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

No Yes When?

Whom may we thank for referring you?

If so, whom?

Gender

Male Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status

Single Married Divorced

Widowed Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?

Yes No

Address

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Who carries this policy?

Self Spouse Parent

First Name

Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

Patient name _____

2. And are the result of (darken circle): An accident or injury
 Work Auto Other _____
 A worsening long-term problem
 An interest in: Wellness Other _____

3. Onset (When did you first notice your current symptoms?) _____

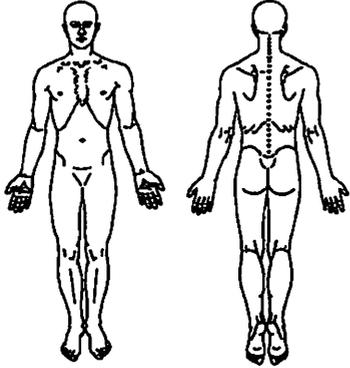
4. Intensity (How extreme are your current symptoms?)
0 10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
 Constant Comes and goes. How Often? _____

6. Quality of symptoms (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other _____

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



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.) _____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Surgery Ice
- Over-the-counter drugs Acupuncture Heat
- Homeopathic remedies Chiropractic Other _____
- Physical therapy Massage _____

11. What else should Dohnal Chiropractic know about your current condition? _____

12. How does your current condition interfere with your:

Work or career: _____
Recreational activities: _____
Household responsibilities: _____
Personal relationships: _____

13. 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 Osteoporosis Arthritis Scoliosis Neck pain Back problems Hip disorders
 Knee injuries Foot/ankle pain Shoulder problems Elbow/wrist pain TMJ issues Poor posture Initials _____

b. Neurological

Had Have Anxiety Depression Headache Dizziness Pins and needles Numbness
Initials _____

c. Cardiovascular

Had Have High blood pressure Low blood pressure High cholesterol Poor circulation Angina Excessive bruising
Initials _____

d. Respiratory

Had Have Asthma Apnea Emphysema Hay fever Shortness of breath Pneumonia
Initials _____

e. Digestive

Had Have Anorexia/bulimia Ulcer Food sensitivities Heartburn Constipation Diarrhea
Initials _____

f. Sensory

Had Have Blurred vision Ringing in ears Hearing loss Chronic ear infection Loss of smell Loss of taste
Initials _____

g. Integumentary

Had Have Skin cancer Psoriasis Eczema Acne Hair loss Rash
Initials _____

Consultation Notes

Doctor's Initials
Dohnal Chiropractic

(Continued from previous page)

h. Endocrine

Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>					
<input type="radio"/> Thyroid issues	<input type="radio"/> Immune disorders	<input type="radio"/> Hypoglycemia	<input type="radio"/> Frequent infection	<input type="radio"/> Swollen glands	<input type="radio"/> Low energy	Initials _____

i. Genitourinary

Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>					
<input type="radio"/> Kidney stones	<input type="radio"/> Infertility	<input type="radio"/> Bedwetting	<input type="radio"/> Prostate issues	<input type="radio"/> Erectile dysfunction	<input type="radio"/> PMS symptoms	Initials _____

j. Constitutional

Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>					
<input type="radio"/> Fainting	<input type="radio"/> Low libido	<input type="radio"/> Poor appetite	<input type="radio"/> Fatigue	<input type="radio"/> Sudden weight change	<input type="radio"/> Weakness	Initials _____

Patient name _____

Initials _____

Initials _____

Initials _____

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.

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>
<input type="radio"/> AIDS	<input type="radio"/> Tuberculosis
<input type="radio"/> Alcoholism	<input type="radio"/> Typhoid fever
<input type="radio"/> Allergies	<input type="radio"/> Ulcer
<input type="radio"/> Arteriosclerosis	<input type="radio"/> Other: _____
<input type="radio"/> Cancer	_____
<input type="radio"/> Chicken pox	_____
<input type="radio"/> Diabetes	_____
<input type="radio"/> Epilepsy	_____
<input type="radio"/> Glaucoma	_____
<input type="radio"/> Goiter	_____
<input type="radio"/> Gout	_____
<input type="radio"/> Heart disease	_____
<input type="radio"/> Hepatitis	_____
<input type="radio"/> Malaria	_____
<input type="radio"/> Measles	_____
<input type="radio"/> Multiple Sclerosis	_____
<input type="radio"/> Mumps	_____
<input type="radio"/> Polio	_____
<input type="radio"/> Rheumatic fever	_____
<input type="radio"/> Scarlet fever	_____
<input type="radio"/> Sexually transmitted disease	_____
<input type="radio"/> Stroke	_____

15. Operations

Surgical interventions, which may or may not have included hospitalization.

<input type="radio"/> Appendix removal
<input type="radio"/> Bypass surgery
<input type="radio"/> Cancer
<input type="radio"/> Cosmetic surgery
<input type="radio"/> Elective surgery: _____

<input type="radio"/> Eye surgery
<input type="radio"/> Hysterectomy
<input type="radio"/> Pacemaker
<input type="radio"/> Spine _____

<input type="radio"/> Tonsillectomy
<input type="radio"/> Vasectomy
<input type="radio"/> Other: _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past <input type="radio"/>	Currently <input type="radio"/>
<input type="radio"/>	<input type="radio"/> Acupuncture
<input type="radio"/>	<input type="radio"/> Antibiotics
<input type="radio"/>	<input type="radio"/> Birth control pills
<input type="radio"/>	<input type="radio"/> Blood transfusions
<input type="radio"/>	<input type="radio"/> Chemotherapy
<input type="radio"/>	<input type="radio"/> Chiropractic care
<input type="radio"/>	<input type="radio"/> Dialysis
<input type="radio"/>	<input type="radio"/> Herbs
<input type="radio"/>	<input type="radio"/> Homeopathy
<input type="radio"/>	<input type="radio"/> Hormone replacement
<input type="radio"/>	<input type="radio"/> Inhaler
<input type="radio"/>	<input type="radio"/> Massage therapy
<input type="radio"/>	<input type="radio"/> Physical therapy
<input type="radio"/>	<input type="radio"/> Nutritional supplements:
List: _____	

Medications (prescription and over-the-counter):

PERSONAL

Consultation Notes

17. Injuries

Have you ever...

<input type="radio"/> Had a fractured or broken bone	<input type="radio"/> Used a crutch or other support
<input type="radio"/> Had a spine or nerve disorder	<input type="radio"/> Used neck or back bracing
<input type="radio"/> Been knocked unconscious	<input type="radio"/> Received a tattoo
<input type="radio"/> Been injured in an accident	<input type="radio"/> Had a body piercing

18. Family History

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

Relative	Age (if living)	State of health		Illnesses	Age at death	Cause of death	
		Good <input type="radio"/>	Poor <input type="radio"/>			Natural <input type="radio"/>	Illness <input type="radio"/>
Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
_____	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

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

20. Social History

Tell Dohnal Chiropractic about your health habits and stress levels.

Alcohol use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes <input type="radio"/> No
Coffee use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes <input type="radio"/> No
Tobacco use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes <input type="radio"/> No
Exercising	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes <input type="radio"/> No
Pain relievers	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes <input type="radio"/> No
Soft drinks	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No
Water intake	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____		
Hobbies: _____				

SOCIAL

Doctor's Initials _____

Dohnal Chiropractic

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect		No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name _____

22. What is the major stressor in your life? _____
23. How much sleep do you average per night? _____ Hours
24. What is the type and approximate age of your mattress and pillow? _____
25. What is your preferred sleeping position? _____
26. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals
27. What would be the most significant thing that you could do to improve your health? _____
28. 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 judgment, 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 X-ray 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 non-covered 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.**

If the patient is a minor child, print child's full name: _____

Doctor's Initials

Dohnal Chiropractic

Signature _____

Date (MM/DD/YYYY) _____