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.

Osmon Chiropractic Center
1332 Arch Haven Ave Ste. C
Bloomington, IN 47403
www.DrOsmon.com
Phone: (812) 333-7447

Today's Date (MM/DD/YYYY) ____________

Have you consulted a chiropractor before? ◯ No ◯ Yes

Patient Number (office use only) ____________

Whom may we thank for referring you? ____________

When? ____________

If so, whom? ____________

Age ____________

Gender ◯ Male ◯ Female

Race ◯ American Indian ◯ Alaskan Native ◯ Asian ◯ Black or African American ◯ Native Hawaiian ◯ Other 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 and Age ____________

Emergency Contact ____________ **Emergency Contact's Phone** ____________

Child's Name and Age ____________

Your Occupation ____________

Child's Name and Age ____________

Your Employer ____________

Work Phone ____________

Address ____________

May we contact you at work? ◯ Yes ◯ No

City ____________ **State/Province** ____________ **ZIP/Postal Code** ____________

Preferred method of contact? ◯ Home Phone ◯ Cell Phone ◯ Work Phone ◯ Email

Primary Care Provider's Name ____________ **Primary Care Provider's Phone** ____________

Insurance Carrier ____________ **Policy Number** ____________

Insured's Last Name ____________ **Birth Date (MM/DD/YYYY)** ____________

Who carries this policy? ◯ Self ◯ Spouse ◯ Parent

Insured's First Name ____________ **Insured's Middle Name (or Initial)** ____________

Insured's Employer ____________

Address ____________

City ____________ **State/Province** ____________ **ZIP/Postal Code** ____________ **Employer's Phone** ____________

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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 __________

◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _______

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

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

◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter 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 __________

◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _______

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

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

◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter 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 __________

◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _______

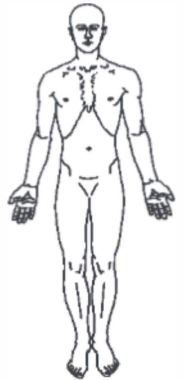
Onset (When did you first notice your current symptoms?) ______________________

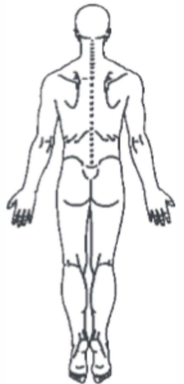
Prior interventions (What have you done to relieve the symptoms?)

◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter 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 Osmon Chiropractic Center 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	◯	◯	Hay fever	◯	◯	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)

____
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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	Illness
○	○	AIDS
○	○	Alcoholism
○	○	Allergies
○	○	Arteriosclerosis
○	○	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
○	○	Tuberculosis
○	○	Typhoid fever
○	○	Ulcer
○	○	Other: ____________

7. Allergies

Are you allergic to any medications?

Yes ○ No ○ If Yes please list: ____________

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

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	Treatment
○	○	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, over-the-counter, natural supplements, enzymes, vitamins and minerals): ____________

Consultation Notes

9. Family History

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

FAMILY

Relative	Age (If living)	State of health: Good	Poor	Illnesses	Age at death	Cause of death: Natural	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 Osmon Chiropractic Center about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? ____
Coffee use	○ Daily	○ Weekly	How much? ____
Tobacco use	○ Daily	○ Weekly	How much? ____
Exercising	○ Daily	○ Weekly	How much? ____
Pain relievers	○ Daily	○ Weekly	How much? ____
Soft drinks	○ Daily	○ Weekly	How much? ____
Water intake	○ Daily	○ Weekly	How much? ____

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

Hobbies: ____________

Doctor's Initials ____________

Osmon Chiropractic Center

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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	◯	◯	◯	◯

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering or bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love life	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Exercising	◯	◯	◯	◯
Yard work	◯	◯	◯	◯

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? ______________________

____

20. Are you currently pregnant? Yes/No **Due date:** ______________________

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 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 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.**

______________________________ Patient (or Guardian's) signature

______________________________ Date (MM/DD/YYYY)

Patient name

Patient Number
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Consultation Notes

Doctor's Initials

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