

Welcome To Bluegrass Chiro Bowling Green

Dr. Nowelle Altman Sigman, D.C.

Date: _____

Patient information

Patient's Name: _____

Address: _____

City: _____

State: _____ Zip _____

Home Phone: _____

Cell Phone: _____

I give Bluegrass Chiro-Bowling Green (Dr. Nowell Altman Sigman) Permission to contact me at the above numbers as well as leave a message if needed.

X _____

Signature

Email Address: _____

___ Check if you would like opt OUT of the text reminders

Gender: ___M ___F Age _____ Birth Date: _____

Patient SS# _____

Occupation _____

Employer: _____

Spouse's Name: _____

Spouse's Birth Date: _____

SS#: _____

Spouse's Occupation: _____

How did you hear about us? ___ yellow pages ___ Internet

___ Person _____

___ Other _____

Who is responsible for this account? _____

Relationship to patient? _____

Insurance: _____

Policy Holder Name? _____

In Case of Emergency, Contact:

Name: _____

Relationship: _____

Contact Number: _____

Patient Condition

Reason for visit _____

Is your condition due to an accident? ___Yes ___No

Type of Accident: ___Auto ___Work ___Home

Date pain began: _____

Is the condition getting: ___Better ___Worse ___Staying the Same

Circle the number below showing how bad your pain is:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (I'd rather be dead)

Type of pain: (circle) Sharp Dull Achy Throbbing Burning

Shooting Numbness Tingling Cramping Stiffness Stabbing

___ Other : _____

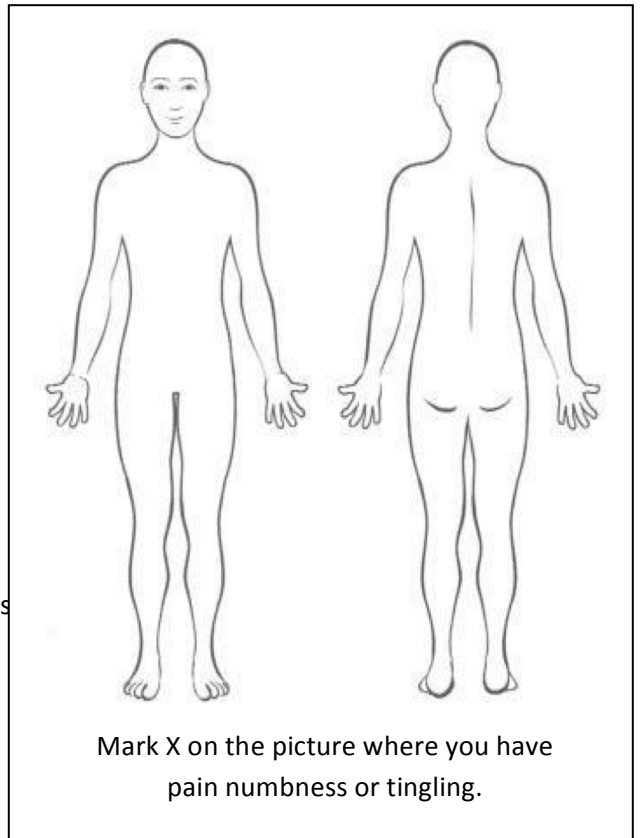
The Pain is: Constant or Comes and Goes

It is difficult to: Sit Stand Walk Bend Lay Down Drive Climb Stairs

My Pain Interferes with: Sleep Work Daily Activities Recreation

I feel better when I: Sit Stand Walk Lie down rest

Use Heat Use Ice Take Advil/Aleve/Ibuprofen/Pain Meds



Health History

What treatment have you already received for this condition? ___ Medication ___ Surgery ___ Physical Therapy
 ___ Chiropractic Services ___ None ___ Other _____

Name and address of other Doctors that have treated you for this condition _____

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT Scan, Bone Scan _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | | | | | | | | |
|------------------|--|------------------|--|--------------------|--|-------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy shots | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors/growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infection | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disc | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid | | Other _____ | |
| Chemical | | | | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | |
| Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | |
| Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraines | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | |

Exercise

- ___ None
 ___ Moderate
 ___ Daily
 ___ Heavy

Work Activity

- ___ Sitting
 ___ Standing
 ___ Light Labor
 ___ Heavy Labor

Habits

- ___ Smoking Packs/Day _____
 ___ Alcohol Drinks/Week _____
 ___ Coffee/Caffeine Cups/Day _____
 ___ High Stress Reason _____

Are you pregnant? ___ Yes ___ No Due Date: _____

Family Medical History: ___ Cardiac conditions ___ Diabetes ___ Cancer ___ Arthritis ___ Other _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone _____	_____	_____