Welcome To Bluegrass Chiro

Dr. Dennis Short, D.C. (Owner)

Date: _____

Patient information

Patient's Name: _____
Address: _____
City:_____
State:_____Zip_____
Home Phone:_____
Cell Phone:_____
I give BluegrassChiro 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?_____
Do you have an HSA or Flex account __Yes __No
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)

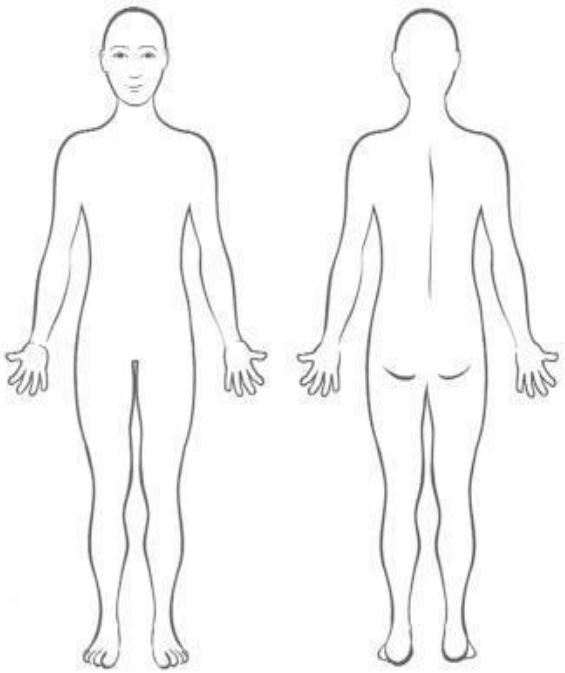
Type of pain: (circle) Sharp Dull Achy Throbbing Burning
Shooting Numbness Tingling Cramping Stiffness Stabbing
___ Other : _____

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



Mark X on the picture where you have pain numbness or tingling.

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

Exercise	**Sleep**	**Work Activity**	**Habits**	
__ None	__Hours per night	__ Sitting	__ Smoking	Packs/Day ____
__Moderate		__ Standing	__ Alcohol	Drinks/Week _____
__ Daily		__ Light Labor	__ Coffee/Caffeine	Cups/Day_____
__ Heavy		__ Heavy Labor	__ Stress: __Mild __Moderate __Severe __Extreme	

The majority of your day is spent: __Seated __Standing __Walking
Women Only: Are you pregnant? ___ Yes ___ No Due Date: _____
Family Medical History: __Diabetes __Heart __Stroke __Cancer __Blood pressure problems __Other _____

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

Medications	**Allergies**	**Vitamins/Herbs/Minerals**
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone_____	_____	_____