Dr. Dennis Cronk Dr. Karyn Marshall
759 Broad Street, Shrewsbury, NJ 07702
(732) 741-1000

CHIROPRACTIC PATIENT HISTORY

Please complete this confidential history questionnaire. The consultation is offered to determine if you are a candidate for chiropractic care. Your answers will help us to help you. The human body is designed to be healthy. Throughout life, events occur which damage your health. This consultation will uncover the layers of damage, especially to your nervous system and spine that can result in poor health. Thank you for choosing CHAMPION CHIROPRACTIC to meet your health care needs.

PATIENT INFORMATION:

Name_____ Age_____ Birth Date_____ Today's Date_____

Address_____City_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email_____ Sex___ Marital Status ___ No. of children _____ Social Security: _____

Occupation: _____Employer:_____

Name of Spouse_____Occupation_____

Person to contact in case of emergency_____Phone _____

Family Physician_____ Phone_____

Whom may we thank for referring you to us? _____

Major Complaints (reason for your visit):

A) _____ C) _____
_____ _____

B) _____ D) _____

1. Which of your major complaints bothers you the most? _____
2. On a scale of 1 to 10, how bad is it? (0 being none; 10 being the worst)_____
3. How long have you had this complaint(s)? _____
4. Prior to this problem beginning, did you ever have an earlier problem that was the same or similar and when? (Explain)_____ _____
5. For your present condition did your pain appear [ ] Slowly [ ] Suddenly?
6. How often does it bother you now? _____
7. When it is at its worst, how does it feel? _____
8. What activities aggravate current condition?_____

9. What do you do to relieve current condition? _____
10. What other treatments have you tried for this condition?
[ ] Chiropractic [ ] Physical Therapy [ ] Anti-inflammatory Medication (NSAIDS) [ ] Pain Medication
[ ]Cortisone Injections [ ] Surgery [ ] Other_____
11. Have any other doctors treated this condition? _____
If so, who and when? _____
12. What testing have you had related to this condition? [ ] xrays [ ] MRI [ ] CAT scan
13. Is this due to an injury from Employment? __ Auto Accident __Personal Injury __
14. How is your current condition affecting you?
[ ] Work, [ ] Home, [ ] Recreational Activities , [ ] Relationships, [ ] Sleep
15. When it is at its worst, how does it interfere with your normal daily activities?
_____
16. Do you think your problem is getting worse? [ ] Yes [ ] No
17. What do you think is causing your pain? _____
18. Women: Are you pregnant or is there any possibility you might be pregnant? _____

SOCIAL HISTORY

If not applicable, write N/A. Please indicate how much you consume of the following per day or weekly.
Alcohol: _____
Coffee: _____
Tobacco: _____
Pain relievers: _____
Soft drinks: _____
Water intake: _____

Please indicate how often you engage in the following per day/week.
Exercise: _____
Hobbies: _____

Rate your food intake: 1 2 3 4 5 6 7 8 9 10
1=Poor-Processed Foods/Take Out/Fast Food 10=Excellent, Organic, Fresh, Healthy

FAMILY HISTORY

RELATIVE	**AGE-** if living	**ILLNESSES**	**Age at Death**
Mother:	____	_____	____
Father	____	_____	____
Sibling 1	____	_____	____
Sibling 2	____	_____	____
Sibling 3	____	_____	____
Sibling 4	____	_____	____

INSURANCE VERIFICATION SECTION:

Primary Insurance Carrier:
Name of Insured _____ Relationship _____
Insured's S.S. # _____Policy # _____ Group#_____
Insurance Company Name _____
Insurance Company Address _____
Insurance Company Telephone Number _____
Company Insured Works For _____

Secondary Insurance Carrier:
Name of Insured _____ Relationship _____
Insured's S.S. # _____Policy # _____ Group#_____
Insurance Company Name _____
Insurance Company Address _____
Insurance Company Telephone Number _____
Company Insured Works For _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I authorize Champion Chiropractic to release any medical or other information necessary to process any health or accident insurance claims to any insurance company, adjuster or attorney involved in this case. I understand that this office will prepare any necessary reports or claim forms to assist me in making collection from the insurance company and that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, and fees for professional services rendered to me will be immediately due and payable. If my delinquent account is sent to a collection agency a 25% collection fee will be added. I certify that the forgoing information and statements are true and correct.

I instruct the Doctor(s) to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health.

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.

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.

Patient's Signature _____ Date _____
Parent's or Guardian's Signature, if patient is a minor _____
Doctor's Signature _____Date _____

Following your examination, we will outline a program of care to begin to correct these layers of damage and to help you recover your health potential. Please let us know if there is any reason that you cannot follow this program of care.

Review of Systems:
Do you CURRENTLY have? (IF YES, CHECK OFF APPROPRIATE CIRCLES)

GENERAL
- o Fatigue
- o Fever
- o Weight Gain > 10 pounds
- o Weight Loss > 10 pounds

SKIN
- o Rash
- o Skin Cancer

HEAD, EYES, EARS
- o Double Vision
- o Decreased Hearing
- o Ear Ache
- o Ear Ringing

GASTROINTESTINAL
- o Abdominal Pain
- o Constipation
- o Diarrhea
- o Nausea
- o Vomiting
- o Food Sensitivities
- o Heartburn/GERD

GENITOURINARY
- o Painful Urination
- o Increased Frequency
- o Kidney Stones
- o Incontinence
- o Bowel or Bladder Impairment

MUSCULOSKELETAL
- o Joint Pain
- o Joint Swelling
- o Joint Stiffness
- o Muscle Aches/Pains
- o Osteoporosis

NEUROLOGICAL
- o Dizziness/Vertigo
- o Headaches
- o Numbness/Tingling
- o Passing out/Fainting
- o Seizures

PSYCHIATRIC
- o Anxiety
- o Change in Sleep Pattern
- o Depression

RESPIRATORY
- o Chronic Cough
- o Decreased Exercise Tolerance
- o Difficulty Breathing
- o Wheezing

CARDIOVASCULAR
- o Chest Pain
- o Leg Swelling
- o Palpitations
- o Shortness of Breath
- o Low Blood Pressure
- o High Blood Pressure

ENDOCRINE
- o Appetite Changes
- o Cold Intolerance
- o Increased Thirst
- o Increased Urination
- o Thyroid Issues

_____ _____ _____

ILLNESSES
Check off the illnesses you have HAD in the past or HAVE now.

Had	Have	
____	____	Alcoholism
____	____	Allergies
____	____	Arteriosclerosis
____	____	Cancer
____	____	Diabetes
____	____	Epilepsy
____	____	Glaucoma
____	____	Heart Disease
____	____	Hepatitis
____	____	HIV/AIDS
____	____	Multiple Sclerosis
____	____	Rheumatic Fever
____	____	Stroke
____	____	Ulcer
____	____	Other _____

ALLERGIES
Are you allergic to any medications?
____Yes ____ No
If YES, please list:
_____
_____
_____

OPERATIONS
____ Appendix Removal
____ Bypass Surgery
____ Cancer
____ Cosmetic Surgery
____ Elective Surgery: _____
_____
____ Eye Surgery
____ Hysterectomy
____ Pacemaker
____ Spine: _____
_____
____ Tonsillectomy
____ Vasectomy
____ Other: _____

TREATMENTS
Check the ones you've received in the PAST or are receiving CURRENTLY.

Past	Currently	
____	____	Acupuncture
____	____	Antibiotics
____	____	Chemotherapy
____	____	Chiropractic Care
____	____	Herbs
____	____	Homeopathy
____	____	Massage Therapy
____	____	Physical Therapy
____	____	Medications

Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins, and minerals:
_____
_____
_____
_____
_____

ACTIVITIES DISCOMFORT SCALE

NAME: _____ DATE: _____

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

	0	1	2	3	4
Activity	Doesn't Hurt	Hurts a Little	Hurts Very Much	Almost Unbearable	Unbearable
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or Jogging					
8. Climbing Stairs					
9. Carrying					
10. Pushing or Pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household Chores					
16. Gardening					
17. Sports					
18. Employment					
Other: _____					
Totals					

COMMENTS: _____

_____

_____

_____

_____

SCORE: _____