INTEGRATIVE HEALTH
and
LEWISTON FAMILY CHIROPRACTIC, LLC
Kurt A. Bailey DC, NMD, FNP

CONFIDENTIAL PATIENT INFORMATION

Name (First/M.I./Last): ______________________________

What would you preferred to be called? ______________________________

Home Phone: ______________ Work Phone: ______________

Cell Phone: ______________ SS #: ______________

Address: ______________________________

E-Mail: ______________________________

Age: ______ Birth Date: ______ / ______ / ______ Male ____ Female ____

Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced # of Children: ________

Occupation: ______________________________

Employer: ______________________________

Address: ______________________________

Spouse Name: ______________________________

Spouse Occupation/Employer: ______________________________

Spouse Home/Cell/Work Phone: ______________________________

Emergency Contact: ______________ Phone: ______________

Have you ever filed for Bankruptcy or Medical Malpractice? ______ Yes _____ No When: __________

How did you hear about our clinic? ______________________________

I understand and agree to that health and accident insurance policies are an arrangement between the insurance company and the patient. Although Dr. Bailey's office will help me bill, I acknowledge that ultimate payment is my responsibility.

Payment or insurance co-payment is expected at the time of service. I authorize the release of any medical or other information necessary to process claims.

Patient Signature: ______________ Date: ______________

Guardian/Spouse Signature Authorizing Care: ______________________________

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

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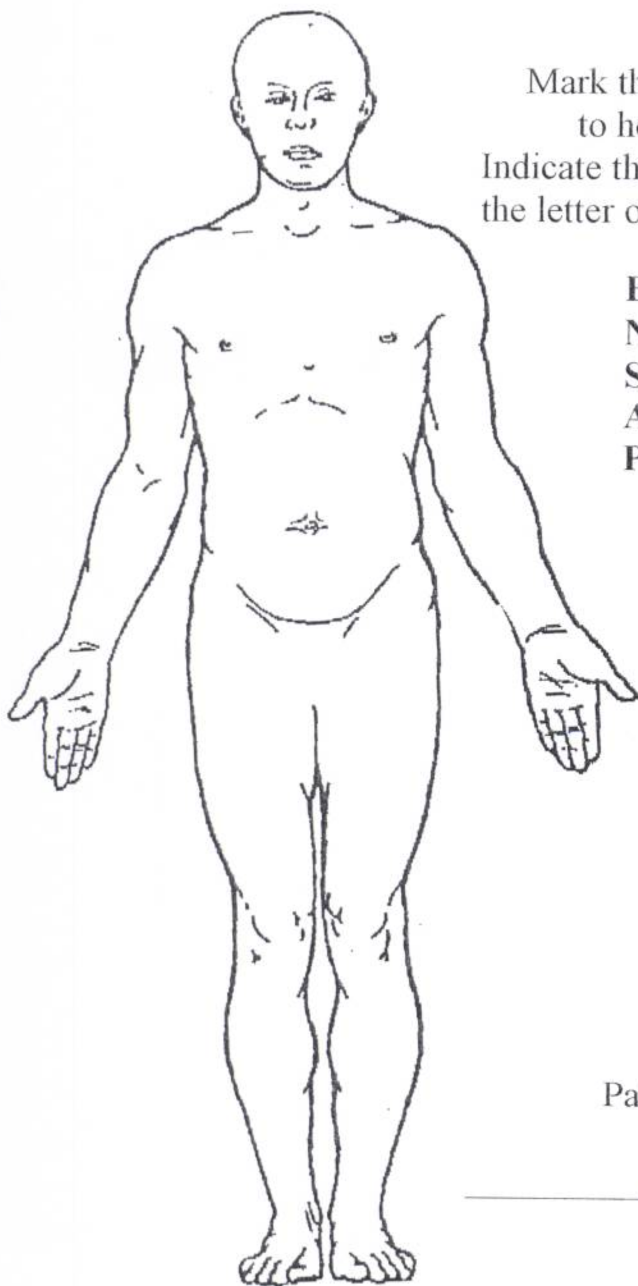
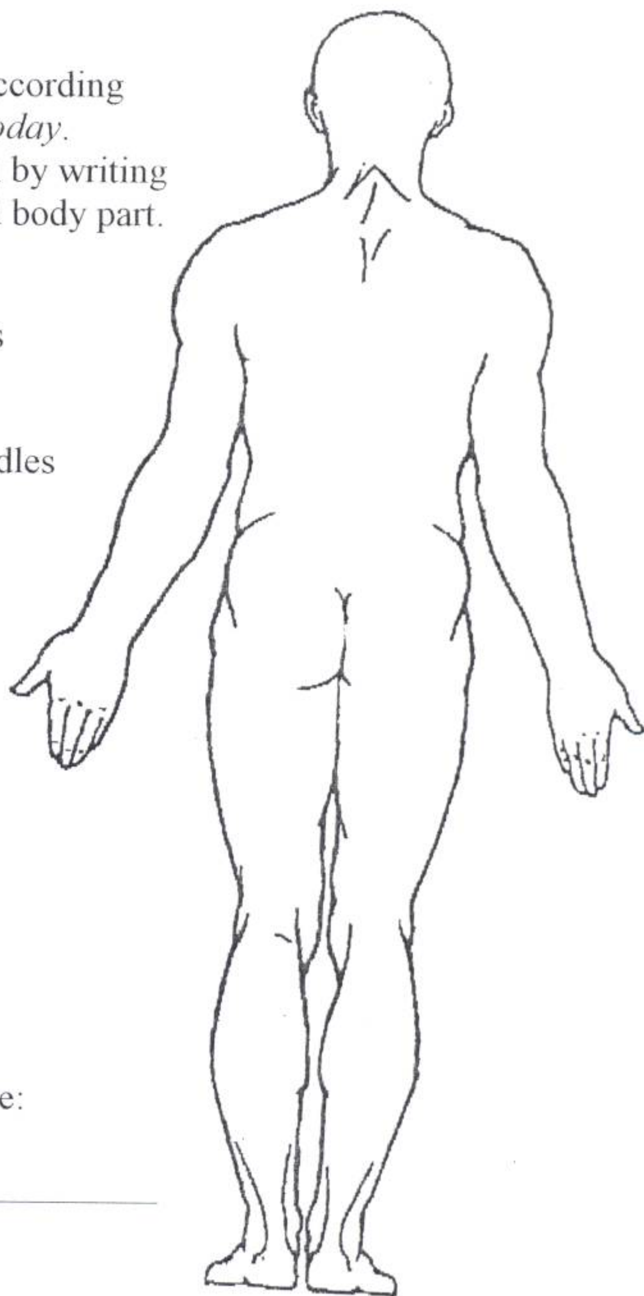
Pain Diagram

Mark with an **X** on the scale according to how you are feeling *today*.



Mark the drawings according to how you feel *today*.
Indicate the type of pain by writing the letter on the affected body part.

B = Burning
N = Numbness
S = stabbing
A = aching
P = Pins / Needles



Patient Signature:

____

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Tobacco:	☐ Yes	☐ No	☐ Quit	☐ Smokeless	Packs per day: ______ # of yrs: _______
Alcohol Use:	☐ None	☐ Occasional	☐ Daily	How much per week? ________	
Recreational Drugs:		☐ No	☐ Yes	☐ Amphetamines	☐ Other: ______________
Caffeine:	☐ Yes	☐ No	How much per day? __________		
Family History:	Father	☐ Deceased	☐ Living	Age: _____	Medical Problems: ________________
	Mother	☐ Deceased	☐ Living	Age: _____	Medical Problems: ________________
	Siblings	☐ Deceased	☐ Living	Age: _____	Medical Problems: ________________
	Spouse	☐ Deceased	☐ Living	Age: _____	Medical Problems: ________________

Please check if you have or had any of the following:

MUSCLES / SKELETAL
- ☐ Arthritis
- ☐ Polio
- ☐ Joint infection, pain, swelling
- ☐ Loss of motion in joints
- ☐ Bone fractures
- ☐ Spine abnormality
- ☐ Brittle or soft bones
- ☐ Bursitis/tendonitis

HEART / CARDIOVASCULAR
- ☐ Chest pain
- ☐ Abnormal heartbeat
- ☐ High/low blood pressure
- ☐ Fingers/toes sensitive to cold
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Rheumatic fever

BREATHING / RESPIRATORY
- ☐ Breathing problems
- ☐ Excessive cough
- ☐ Night sweats
- ☐ Allergy/cold symptoms
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Asthma
- ☐ TB

EARS / HEARING
- ☐ Loss of hearing
- ☐ Buzzing or noise in ear

NEUROLOGICAL / MIGRAINES
- ☐ Severe/frequent headaches
- ☐ Dizziness/fainting spells
- ☐ Seizures/convulsions
- ☐ Shaking/twitching limbs
- ☐ Paralysis of limbs

NOSE / THROAT
- ☐ Hoarseness
- ☐ Blocked nasal passages
- ☐ Nose bleeds
- ☐ Difficulty swallowing
- ☐ Allergies

URINARY
- ☐ Bloody urine
- ☐ Painful/difficult urination
- ☐ Kidney/urine problems
- ☐ Flank pain

STOMACH / INTESTINES
- ☐ Frequent nausea/ vomiting
- ☐ Bloody vomitus
- ☐ Stomach, abdominal, bowel pain
- ☐ Recurring diarrhea
- ☐ Blood in stools
- ☐ Hemorrhoids
- ☐ Frequent/severe constipation
- ☐ Diabetes, gallbladder disease
- ☐ Hernia

EYES / VISION
- ☐ Eye pain or redness
- ☐ Loss or change of vision
- ☐ Double or blurred vision
- ☐ Corrective glasses/contacts

EMOTIONAL
- ☐ Emotional illness
- ☐ Depression
- ☐ Anxiety
- ☐ Feelings of worthlessness
- ☐ Physical abuse
- ☐ Frequent nightmares
- ☐ Hysterical attacks
- ☐ Difficulty sleeping

MALE
- ☐ Abnormality of testicles
- ☐ Varicocele
- ☐ Difficulty in sexual function
- ☐ Genital pain
- ☐ Plastic Surgery

FEMALE
- ☐ Breast pain
- ☐ Breast implants/reduction
- ☐ Uterine fibroids/tumors
- ☐ Painful menses/excessive bleeding
- ☐ Genital pain
- ☐ Difficulty in sexual function
- ☐ Plastic Surgery

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1. **Present Complaint:** ______________________________

2. **When did your problem begin?** ____________________ (specific date if possible)

3. **Did your problem begin:**
   ☐ Immediately after a specific incident ☐ Multiple incidents ☐ Gradually developed ☐ No specific reason

4. **How often are the complaints present?**
   ☐ Constant (100-76%) ☐ Frequent (75-51%) ☐ Occasional (50-26%) ☐ Intermittent (less)

5. **Since your problem began is the pain:** ☐ Increasing ☐ Decreasing ☐ Not Changing

6. **Please describe the character of your current pain (check all that apply):**
   ☐ Numbness ☐ Shooting ☐ Sharp/Dull ☐ Dull ☐ Aches ☐ Burning ☐ Soreness
   ☐ Weakness ☐ Tingling ☐ Throbbing/Gnawing ☐ Gripping/Constricting ☐ Sharp/Stabbing

7. **What treatment have you received for this present condition?**
   ☐ Surgery ☐ Spinal injections ☐ Physical Therapy ☐ Massage Therapy ☐ Pain Clinic
   ☐ Medications: ☐ Over the Counter *or* ☐ Prescription ☐ Other: ____________________

8. **Were you previously treated for a different occurrence of this same condition?**
   ☐ No ☐ Yes If yes by: ☐Chiropractor ☐ MD ☐ Therapy ☐ Massage ☐ Pain Clinic

9. **What makes your problem better?**
   ☐ Nothing ☐ Lying Down ☐ Sitting ☐ Standing
   ☐ Walking ☐ Inactivity ☐ Movement/Exercise ☐ Other: ____________

10. **What makes your problem worse?**
    ☐ Nothing ☐ Lying Down ☐ Sitting ☐ Standing
    ☐ Walking ☐ Inactivity ☐ Movement/Exercise ☐ Other: ____________

11. **How would you grade your general stress level?**
    ☐ No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

12. **Physical activity at work:**
    ☐ Sitting more than 50% of the day ☐ Light labor ☐ Manual labor ☐ Heavy manual labor

13. **General physical activity:**
    ☐ No regular exercise program ☐ Light exercise program ☐ Strenuous exercise program

14. **Are your complaints affecting your ability to work or otherwise be active?**
    ☐ No effect ☐ Some restrictions (can perform light duty work/household tasks)
    ☐ Need assistance often ☐ Need limited assistance with common everyday tasks
    ☐ Have a significant inability to function without assistance
    ☐ Am totally disabled (impaired), cannot care for self

Patient Signature: ______________________________ **Date:** ______________

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Current Family Physician: ______________________________

Current pharmacy / pharmacist: ______________________________

Please list any medications, vitamins or supplements that you are currently taking:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Please list any known allergies and your reaction to them:

1. ______________________________

   Reaction: ______________________________

2. ______________________________

   Reaction: ______________________________

3. ______________________________

   Reaction: ______________________________