Oakwood Chiropractic & Wellness
Dr. Stuart J. Yeager

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Confidential Patient History

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we do not accept your case. Thank you.

NAME________________________________ SEX M/F _________ DATE____________________ AGE_______
ADDRESS________________________________ CITY____________________ STATE_____ ZIP__________
BIRTH DATE__________________ S.S.#_________________ HOME PHONE____________________
WORK PHONE__________________ CELL PHONE__________________ MARITAL STATUS S/M/D
SPOUSE____________________ WHO IS RESPONSIBLE FOR THIS ACCOUNT________________________
EMERGENCY CONTACT______________________ PHONE #__________________ EMAIL__________________
REFERRED BY____________________ Yellow Pages Advertisement Insurance Plan Other______________________

Please check the appropriate box for any of the following symptoms you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL REPORT.

N- now present
P- past experienced

N P
0 0 Dizziness
0 0 Drop attacks (fainting)
0 0 Diplopia (visual disturbances)
0 0 Dysarthia (difficulty speaking)
0 0 Dysphasia (difficulty swallowing)
0 0 Ataxia (difficulty walking)
0 0 Nausea
0 0 Numbness
0 0 Allergy
0 0 Chills
0 0 Convulsions
0 0 Fatigue
0 0 Fever
0 0 Headache
0 0 Loss of sleep
0 0 Loss of weight
0 0 Excessive hunger
0 0 Sweats
0 0 Anxiety
0 0 Depression

MUSCLE & JOINT
0 0 Arthritis
0 0 Bursitis
0 0 Foot trouble
0 0 Hernia
0 0 Low back pain
0 0 Neck pain/stiffness
0 0 Pain between shoulders
0 0 Painful tail bone
0 0 Sciatica
0 0 Spinal Curvature
0 0 Swollen joints

N P
Pain or numbness in
0 0 shoulders
0 0 Arms
0 0 Elbows
0 0 Hands
0 0 Hips
0 0 Legs
0 0 Knees
0 0 Feet

GASTRO-INTESTINAL
0 0 Belching or gas
0 0 Colon trouble
0 0 Constipation
0 0 Diarrhea
0 0 Difficult digestion
0 0 Distention of abdomen
0 0 Hardening of the arteries
0 0 Gall bladder trouble
0 0 Hemorrhoids
0 0 Intestinal Worms
0 0 Jaundice
0 0 Liver trouble
0 0 Pain over stomach
0 0 Poor appetite
0 0 Vomiting
0 0 Vomiting blood

EYES/EARS/NOSE/THROAT
0 0 Asthma
0 0 Colds
0 0 Crossed eyes
0 0 Deafness
0 0 Dental decay

N P
0 0 Earache
0 0 Ear discharge
0 0 Ear noises/ Tinnitis
0 0 Enlarged glands
0 0 Enlarged thyroid
0 0 Eye pain
0 0 Failing vision
0 0 Gum trouble
0 0 Hay fever
0 0 Hoarseness
0 0 Nasal obstruction
0 0 Nosebleeds
0 0 Sinus infection
0 0 Sore throat
0 0 Tonsillitis

CARDIO- VASCULAR
0 0 Kidney stones
0 0 High blood pressure
0 0 Low blood pressure
0 0 Pain over heart
0 0 Poor circulation
0 0 Rapid heart beat
0 0 Slow heart beat
0 0 Swelling of ankles

RESPIRATION
0 0 Chest pain
0 0 Chronic cough
0 0 Difficult breathing
0 0 Spitting up blood
0 0 Spitting up phlegm
0 0 Wheezing

N P
SKIN
0 0 Boils
0 0 Bruise easily
0 0 Dryness
0 0 Hives or allergy
0 0 Itching
0 0 Skin eruptions
0 0 Varicose veins

GENITO-URINARY
0 0 Bed wetting
0 0 Blood in urine
0 0 Frequent urination
0 0 Incontinence (bladder cont.)
0 0 Nervousness infection
0 0 painful urination
0 0 prostate trouble
0 0 pus in urine

N P
WOMEN ONLY
0 0 Congested breasts
0 0 cramps or aches
0 0 excessive menstrual flow
0 0 Hot flashes
0 0 Irregular cycle
0 0 menopausal symptoms
0 0 Painful menstruation
0 0 Vaginal discharge

Are you pregnant: Y/N
List pregnancies:
_______ births
________miscarriages

CHECK ANY CONDITONS YOU HAVE HAD:

0 Alcoholism
0 Anemia
0 Appendicitis
0 Arteriosclerosis
0 Arthritis
0 Cancer
0 Cold sores
0 Diabetes
0 Diphtheria
0 Eczema
0 Emphysema
0 Epilepsy
0 Fever blisters
0 Goiter
0 Gout
0 Heart disease
0 Influenza
0 Malaria
0 Measles
0 Multiple Sclerosis
0 Mumps
0 Pleurisy
0 Pneumonia
0 Polio
0 Rheumatic fever
0 Scarlet fever
0 Stroke
0 Tuberculosis
0 Typhoid fever
0 Ulcers
0 Venereal disease
0 Whooping cough

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1. What is your major complaint?
2. What does this complaint keep you from doing?
3. How long have you had this condition? Have you had a similar condition in the past?
4. What aggravates this condition?
5. Is this condition getting progressively worse? () yes () no () constant () comes and goes
6. Is this condition interfering with your: () work () sleep () daily routine () other
7. List previous diagnoses and/or treatments that you have received for this condition.
8. Other complaints?
9. What do you believe is wrong with you?
10. List all surgical operations you have had and when.
11. Drugs you now take.
    () nerve pills () pain killers () muscle relaxors () "pep" pills () tranquilizers () birth control () others

12. Have you ever had oral surgery? ()yes () no
13. Are you wearing: () sole lifts () heel lifts () inner soles () arch supports
14. Have you been in an auto accident? () past year () past 5 years () over 5 years () never
    Describe

15.. F AMIL Y HEALTH HISTORY-Many health problems are a result of hereditary weakness, thus information about your family will give us a better idea of your total health picture.
Side of the family (mother or father) Relation Past and Present Health Problems

16. Have you ever been:

YES NO Knocked unconscious

YES NO Been treated for a spine or nerve disorder

YES NO Had a fractured bone

YES NO Been hospitalized

17. Do you ever:

Take vitamins and minerals? ____________________

____

Have an allergy to any drug? ____________________

18. Have you ever have previous chiropractic care? YES NO Where?____________________

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Consent to treatment I agree to be treated by Dr. Yeager and technicians for my health questions and health concerns. This treatment may include, but no be limited to, chiropractic care including adjustments, myofascial therapy, traction, percussive massage, electrical muscle stimulation therapy, exercises, laser, neuromuscular re-education, foot baths, and more. I also understand assessments through applied kinesiology along with general muscle testing.

I understand that this is not a guarantee to a cure for any condition but do understand that the body has the ability to hea itself and that the treatments given will help enable the body to heal. I understand that I am not being treated for cancer, diabetes or any other life threatening condition, but may be treated for the pain and discomfort of these possible conditions. I understand that it is my responsibility to inform Dr. Yeager of any changes in my health condition. I also understand that the staff of Dr. Yeager will not advise me on the use or change of any prescription medication I may be taking.

I agree to follow any information or data relating to my case to be used for future research/statistical purposes. Any personal identifying information from my case will be strictly confidential and my personal privacy will be protected. I understand that occasionally visiting doctors and or staff to the clinic may be present for the observation of my care.

Patient Name (printed) ____

Patient's Signature____________________________________ Date__________________

Guardian or Spouse's Signature Authorizing Care_______________________________ Date______________