Staggs Chiropractic & Wellness Center
Confidential Patient History

Today's Date: _____ Referred to our office by: _____

Title: __Mr. __Mrs. __Ms. __Dr.

Last: _____ First: _____ Middle: _____ Preferred Name: _____

Birth Date: ___/___/_____ Age: _____ Sex: __Male __Female SSN: _____

Marital Status: __Single __Married __Widowed __Divorced

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____ Email: _____

Your Employer: _____ Job Title: _____

Spouses Name: _____ Spouse's Employer: _____

Children (Names & Ages): _____

Emergency Contact: (Name) _____ Phone: _____

Do You Have Insurance? _____ Name Of Company: _____ Policy #: _____

Previous chiropractor? _____ Last visit to the chiropractor? _____

Reason for leaving: _____

Present medical doctor or nurse practitioner: _____

I acknowledge that I have received a copy of Staggs Chiropractic's privacy policy. I also acknowledge that although Staggs Chiropractic may submit insurance billings on my behalf, I am still responsible for any and all of the services provided at Staggs Chiropractic. I give permission to Staggs Chiropractic to send necessary records to my insurance company and/or attorney in order to process insurance claims. Additionally, I give my consent to be treated by the doctors at Staggs Chiropractic.

Patient Signature: _____ Date: _____

If the patient listed above is a minor, I consent to Dr. Staggs treating (minor's name) _____.
I further agree to the acknowledgements above.

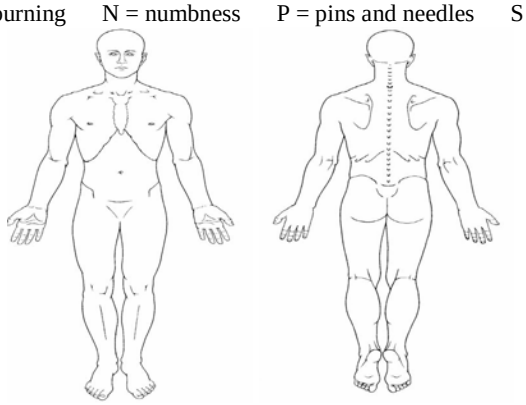
Name Of Parent/Guardian: _____ Relationship: _____

Signature Of Parent/Guardian: _____ Date: _____

Patient Name: _____

Place the proper letter(s) below on the area(s) of the diagram to indicate the symptoms you are experiencing:

A = ache B = burning N = numbness P = pins and needles S = sharp/stabbing



Circle the level of the severity of the symptoms on a scale from 0 to 10 with 0 being none and 10 being severe.

Neck 0-1-2-3-4-5-6-7-8-9-10	Arm 0-1-2-3-4-5-6-7-8-9-10
Headache 0-1-2-3-4-5-6-7-8-9-10	Hand 0-1-2-3-4-5-6-7-8-9-10
Upper back 0-1-2-3-4-5-6-7-8-9-10	Leg 0-1-2-3-4-5-6-7-8-9-10
Mid back 0-1-2-3-4-5-6-7-8-9-10	Foot 0-1-2-3-4-5-6-7-8-9-10
Low back 0-1-2-3-4-5-6-7-8-9-10	Other: _____ 0-1-2-3-4-5-6-7-8-9-10
Pelvis 0-1-2-3-4-5-6-7-8-9-10	Other: _____ 0-1-2-3-4-5-6-7-8-9-10

When did the symptoms begin? _____
What caused the symptoms: _____
Are the symptoms: __constant __frequent __intermittent __occasional
Are the current symptoms the result of a recent accident or injury? ___yes ___no
If yes, explain: _____
What makes the symptoms worse: _____
What makes the symptoms better? _____
Have you ever had these symptoms before? _____ When? _____
What have you tried to get rid of the symptoms that **DID NOT** work?_____
List the medications and dosages you currently take: _____
_____
_____
Was your problem caused at work? _____ If so, how? _____
List any surgeries, significant illnesses or injuries you have had (include dates):_____
_____
_____
_____

For Women Only

Date of your last menstrual period: _____
Do you experience severe cramping with your menstrual period? _____
Do you suffer from PMS? _____
Are you pregnant? _____ If so, what is your due date? _____

Patient Signature: _____ Date: _____

Patient Name: _____

Personal & Family Health History

Please review the diseases and conditions below and indicate those that apply using the following:

C = current condition P = past condition

Leave spaces blank if it does not apply

	You	Father	Mother	Siblings
ADHD				
Allergies				
Arthritis				
Asthma				
Autism				
Back Trouble				
Bed Wetting				
Bursitis				
Cancer				
Constipation				
Crohn Disease				
Depression				
Diabetes				
Diarrhea				
Ear Infection				
Emotion Issues				

	You	Father	Mother	Siblings
Emphysema				
Epilepsy				
Headaches				
Migraines				
Heartburn				
Heart Trouble				
High Blood Press				
IBS				
Indigestion				
Infertility				
Insomnia				
Kidney Trouble				
Nervousness				
Scoliosis				
Sinus Trouble				
Other:				

Activities Of Daily Living

Please check appropriate box for each activity

	Able to do alone	Need help to do	Cannot do
Bathing			
Dressing			
Grooming			
Mouth Care			
Toileting			
Walking			
Climbing Stairs			
Eating			

	Able to do alone	Need help to do	Cannot do
Shopping			
Cooking			
Managing Medications			
Housework			
Laundry			
Driving			
Using Phone			
Managing Finances			

Is there any other information you would like to share with us? _____

_____

_____

Patient Signature: _____ Date: _____