CONFIDENTIAL HEALTH INFORMATION

Cooper Chiropractic Center Inc
Dr. Dale Cooper
101 N. Garden Ave. Ste. 100
Clearwater, FL 33755
727-446-1141
www.drdalecooper.com

Please allow our staff to photocopy your driver's license.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
○ No ○ Yes **When?** **If so, whom?**

Whom may we thank for referring you?

Gender
○ Male ○ Female

Your Last Name **Your Social Security Number**

Your First Name **Your Middle Name (or Initial)** **Birth Date (MM/DD/YYYY)**

Marital Status
○ Single ○ Married ○ Divorced
○ Widowed ○ Separated

Address

City **State/Province** **ZIP/Postal Code** **Home Phone** **Spouse's Name**

Email Address **Cell Phone** **Child's Name and Age**

Emergency Contact **Phone** **Child's Name and Age**

Your Occupation **Child's Name and Age**

Your Employer

May we contact you at work?
○ Yes ○ No

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

Address

City **State/Province** **ZIP/Postal Code** **Work Phone**

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

_____

Patient name _____

2. And are the result of (darken circle): ◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

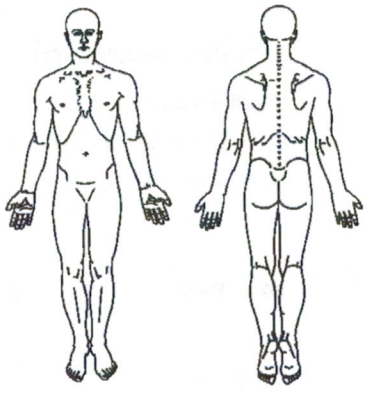
3. Onset (When did you first notice your current symptoms?)
_____

4. Intensity (How extreme are your current symptoms?)
0 ◯—◯—◯—◯—◯—◯—◯—◯—◯—◯ 10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
◯ Constant ◯ Comes and goes. How Often? _____
_____

6. Quality of symptoms (What does it feel like?)
◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other _____
◯ Physical therapy ◯ Massage _____

11. What else should Dr. Cooper know about your current condition? _____
_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture

NONE ◯ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness

NONE ◯ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising

NONE ◯ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia

NONE ◯ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea

NONE ◯ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste

NONE ◯ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash

NONE ◯ Initials ____

Consultation Notes

Doctor's Initials _____

Cooper Chiropractic Center Inc
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h. Endocrine

Had Have
- ○ ○ Thyroid issues
- ○ ○ Immune disorders
- ○ ○ Hypoglycemia
- ○ ○ Frequent infection
- ○ ○ Swollen glands
- ○ ○ Low energy

NONE ○ Initials ____

i. Genitourinary

Had Have
- ○ ○ Kidney stones
- ○ ○ Infertility
- ○ ○ Bedwetting
- ○ ○ Prostate issues
- ○ ○ Erectile dysfunction
- ○ ○ PMS symptoms

NONE ○ Initials ____

j. Constitutional

Had Have
- ○ ○ Fainting
- ○ ○ Low libido
- ○ ○ Poor appetite
- ○ ○ Fatigue
- ○ ○ Sudden weight gain/loss (circle one)
- ○ ○ Weakness

NONE ○ Initials ____

Patient name

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had Have
- ○ ○ AIDS
- ○ ○ Alcoholism
- ○ ○ Allergies
- ○ ○ Arteriosclerosis
- ○ ○ Cancer
- ○ ○ Chicken pox
- ○ ○ Diabetes
- ○ ○ Epilepsy
- ○ ○ Glaucoma
- ○ ○ Goiter
- ○ ○ Gout
- ○ ○ Heart disease
- ○ ○ Hepatitis
- ○ ○ HIV Positive
- ○ ○ Malaria
- ○ ○ Measles
- ○ ○ Multiple Sclerosis
- ○ ○ Mumps
- ○ ○ Polio
- ○ ○ Rheumatic fever
- ○ ○ Scarlet fever
- ○ ○ Sexually transmitted disease
- ○ ○ Stroke
- ○ ○ Tuberculosis
- ○ ○ Typhoid fever
- ○ ○ Ulcer
- ○ ○ Other: _____

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past Currently
- ○ ○ Acupuncture
- ○ ○ Antibiotics
- ○ ○ Birth control pills
- ○ ○ Blood transfusions
- ○ ○ Chemotherapy
- ○ ○ Chiropractic care
- ○ ○ Dialysis
- ○ ○ Herbs
- ○ ○ Homeopathy
- ○ ○ Hormone replacement
- ○ ○ Inhaler
- ○ ○ Massage therapy
- ○ ○ Physical therapy
- ○ ○ Nutritional supplements:

List: _____

- ○ ○ Medications (prescription and over-the-counter):

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Dr. Cooper about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health Good	Poor	Illnesses	Age at death	Cause of death Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
		○	○			○	○

19. Are there any other hereditary health issues that you know about? _____

20. Social History

Tell Dr. Cooper about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much?	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much?	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much?	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much?	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much?	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much?	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much?			

Hobbies: _____

Doctor's Initials

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21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? _____ **Hours**

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

_____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **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.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **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.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

_____ Signature

_____ Date (MM/DD/YYYY)

Patient name

Consultation Notes

Doctor's Initials

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