



Pomperaug CHIROPRACTIC AND HOLISTIC CENTER, PC

3 Pomperaug Office Park, Suite 103
Southbury, CT 06488 (203) 264-3583

*You ought not to attempt to cure
eyes without head, or head without body,
so you should not treat body without soul*

- Socrates

Patient History

Name _____ Date _____

Address _____ City _____

State _____ Zip _____ Home Phone _____ Cell _____

Work phone _____ Date of Birth _____ Age _____

Occupation _____ Employer _____

Marital Status S M D W Number of Children and Ages _____

Social Security # _____ E-Mail Address _____

Referred By _____ and _____

Name of Emergency Contact _____ Phone # _____

Insurance

Insurance Co. _____ Name of Insured _____

Date/Birth _____ ID # _____ Group # _____

Employer _____

Accident Information

Is this condition the result of an Auto or Work related accident? Yes ___ No ___ Work ___ Auto ___

Date of Accident _____ Nature of Accident _____

Medical Release/Assignment of Benefits

I authorize Pomperaug Chiropractic & Holistic Center, PC to release any Protected Health Information necessary to process my claims for health care benefits. I agree to assign the benefits of my insurance carrier to Pomperaug Chiropractic Center. I understand that I am fully responsible for any unpaid or unassigned portion of charges incurred at this office. ***Regardless of insurance status, charges for services rendered are ultimately the patient's responsibility.***

Permission to Communicate Confidential Health Information

I authorize Pomperaug Chiropractic & Holistic Ctr., PC to communicate confidential health Information to me via the following confidential formats: _____ Email Listed Above; _____ Voicemail/Answering Machine at the following number: _____; _____ Only speak directly with me!

Patient's Signature _____ **Date** _____

(Parent or guardian of minor)

Name: _____

Date: _____

General Health Information

Height _____ Weight _____ Left/Right Handed _____ Do you have a Pacemaker? Yes / No

Have you ever received chiropractic care before? Yes / No Drs. Name _____

Have you undergone previous chiropractic or physical therapy during this calendar year? _____

List any diseases or health conditions you now have, or have been treated for in the past. (Give a brief description): _____

List any known allergies: _____

List any other traumas or injuries: _____

List any hospitalizations or surgeries: _____

When was your last complete physical? _____ Blood Tests: Y/N X-rays? (body-part): _____

Other Tests (describe) _____ Results? _____

Who is your primary doctor? _____ Address _____ Phone _____

Date of last visit to primary doctor: _____ Reason for visit: _____

Family History - Check all that apply

	Stroke	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Mother's Side	___	___	___	___	___	___
Father's Side	___	___	___	___	___	___

Current Symptoms

Why are you consulting the doctor? _____

When did this pain or condition begin? _____ Pain is: ___Sharp ___Dull ___Constant ___Intermittent

Rate your symptoms on a scale from 0 – 10: (0=None, 10=Intolerable), please circle: **1 2 3 4 5 6 7 8 9 10**

Does your pain radiate or move? Yes/No If so, where? _____

What aggravates your condition/pain? _____

What relieves your condition/pain? _____

Is the condition worse at certain times of the day? When? _____

What activities are limited due to your condition? _____

Is the condition getting progressively worse? _____

Previous doctors or treatments? _____

Any home remedies used? _____

Have you ever had same/similar condition before? Explain: _____

Check any of the following symptoms, which you have now or have had in the past. N=now P=past

- | | | |
|------------------------------------|--|----------------------------------|
| ___ Headaches | ___ Pins & Needles in Arms/Legs | ___ Cold Hands/Feet |
| ___ Neck Pain | ___ Numbness in Fingers/Toes | ___ Panic Attacks |
| ___ Back Pain | ___ Feeling of Anxiety | ___ Stomach upset/Ulcers |
| ___ Chest Pain | ___ Irregular Heart Rate | ___ Irritable bowel/Colitis |
| ___ Neck Stiff | ___ Shortness of Breath/Asthma | ___ Leg/feet cramps at night |
| ___ Ears Ring/Buzz | ___ Tension/Irritability | ___ Unexplained Fever |
| ___ Sleeping Difficulties | ___ High Blood Pressure | ___ Eczema/Skin Rashes |
| ___ Clench/Grind Teeth | ___ Cold Sores/Fever Blisters | ___ Severe Menstrual Cramps |
| ___ Dizziness/Vertigo | ___ Depression/S.A.D. | ___ Chronic Fatigue |
| ___ Roving muscle/joint Pain | ___ Alcoholism/Addictions | ___ Eyes very sensitive to light |
| ___ Recent unexplained weight loss | ___ Recent change in bowel or bladder function | |

Name: _____

Date: _____

About Holistic Health Care

As represented by our logo, the body, mind and spirit are interconnected components of whole health. One's optimum health potential will be reached only when a "balance" exists between these three components. Pain and disease are often "symptoms" which result from imbalance in our lives. This form will aid us in discovering symptoms and "dis-ease" which may be related to imbalances in your life. Be assured that immediate referral will be made with the discovery of any disease or symptom which necessitates more immediate and specialized medical care. Those who are in need of more specialized medical intervention will often benefit from the addition of holistic chiropractic health care.



The Body

Comments

- Yes / No Do you exercise regularly? In what way? _____
- Yes / No Do you eat properly? What foods do you crave? _____
- Yes / No Do you drink alcohol? Avg. daily intake? _____
- Yes / No Do you consume caffeinated beverages? Avg. daily intake? _____
- Yes / No Have you ever smoked? How long? Average daily amount? _____
- Yes / No Difficulty sleeping or falling asleep? Avg. hours of sleep? _____
- Yes / No Are you taking any drugs? (Prescriptive or non-prescriptive) List drug, dosage, reason for taking _____
- _____
- _____
- Yes / No Do you take vitamins or natural remedies? List supplement & dosage: _____
- _____



The Mind

- Yes / No Do you often feel rushed? _____
- Yes / No Do you easily lose your train of thought? _____
- Yes / No Is it difficult to shut off or slow your thoughts? _____
- Yes / No Are you intolerant of other's mistakes? _____
- Yes / No Do you prefer to be in control of situations? _____
- Yes / No Is it difficult to motivate yourself? _____



The Spirit

- Yes / No Do you consider yourself spiritual? _____
- Yes / No Do you feel a strong sense of purpose? _____
- Yes / No Are you satisfied with your life? _____
- Yes / No Do you pray or meditate regularly? _____

Life Events - Check any of the following that have occurred within the last 3 years

- | | | |
|-------------------------------|--------------------------------|-------------------------------|
| ___ Death of a Loved One | ___ Divorce/Separation | ___ Marriage/Family Additions |
| ___ Job/Career Change | ___ Personal injury/illness | ___ Illness of a Loved One |
| ___ Change of Residence | ___ Change in Financial Status | ___ A Difficult Relationship |
| ___ Starting/Finishing School | ___ Child Leaving Home | ___ Business Difficulties |

List any major life events, (good or bad), which you anticipate within the next year: _____
