Martin Chiropractic & Wellness, & Schrage Chiropractic

Offices of Dr. Leslie Martin & Dr. Jennifer Howard (Schrage)

3675 N 129th Street | Omaha, NE 68164

Patient Health History

Legal Name_____
First MI Last

Address _____

City_____ **State**_____ **Zip Code** _____

Cell Phone _____**Home Phone** _____

Email: _____ **(used for reminders/online scheduling)**

Patient Identification: **********ALL INFORMATION REQUIRED**********

Date of Birth: / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other Spouse Name:_____

Patient SSN - - (minimum last 4 digits)

How did you hear about our office? Whom may we thank for your referral? *(check one)*

❑ Family Member*	❑ Internet Web Site	❑ Other Chiropractor	❑ Google
❑ ICPA Website	❑ Sign on Building	❑ Support Group	❑ Yahoo
❑ Friend*	❑ Insurance Website	❑ Phone Book	❑ Bing
❑ Physician*	❑ Other*	❑ Facebook	❑ YELP

*Please Let us know whom to thank for your referral: _____

Employment Status: *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Employer Name: _____ Phone: _____

Insured Data Policy Holder: *(check one if filing to insurance)*

❑ Self ❑ Spouse ❑ Parent ❑ Other ❑ Employee

Insured's Name: _____ **Date of Birth** / /

Secondary Insurance Insured's Name: _____ **Date of Birth** / /

Staff Use: Coverage Type Chiropractic Acupuncture

Deductible _____ Co-Pay_____ Co-Insurance_____% Max Visits _____

Emergency Contact

Name: _____ Phone: _____

Relation *(check one)* ❑ Spouse ❑ Sibling ❑ Parent ❑ Friend ❑ Employee

Appointment Reminders

Reminders are automatically set up, if you wish to OPT out of Reminders reply STOP to the messages.

Do you currently USE Tobacco of any kind? ❑ Yes ❑ Former Tobacco Use ❑ Never Tobacco Use

Have you had an X-ray or CT scan or MRI of your low back spine in the past Month? ❑ Yes ❑ No

Have you ever seen a Chiropractor, M.D. or D.O. for Spinal Manipulation before? ❑ Yes ❑ No

Have you ever had Acupuncture before? ❑ Yes ❑ No

List current MEDICATIONS and or Over-the-counter Medications/Supplements

If there are no current medications, check here: ❑

_____

_____

List any known MEDICATION or Food ALLERGIES:

If no allergies are known, check here: ❑

_____

_____

To Be Performed by Clinic Staff: Date_____ Staff _____

Height _____ Weight _____ Blood Pressure _____/_____ Pulse _____O2_____

Muscle Grip Right ____ _____ _____ Left ____ ____ _____ L R Bi Norm or Weakness: Mild Moderate Severe

Orthopedic Evaluation/Range of Motion/Reflexes:

Reason for visit today (primary complaint):

_____

_____

When did your symptoms start? / /

Rate your intensity of pain for the region of complaint: (0= No Pain 5 = Moderate 10 = Unbearable)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What event or activity brought on your symptoms? _____

How often do you experience your symptoms throughout the day?

☐ 0 % ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

What describes the nature of your symptoms: ☐ Aching ☐ Burning ☐ Catching ☐ Cramping ☐ Dull

☐ Numbness ☐ Pinprick ☐ Radiating (Traveling) ☐ Sharp ☐ Sharp with Movement ☐Stabbing

☐ Throbbing ☐ Tightness ☐ Tingling ☐ Cramping ☐Weakness ☐ Other _____

What makes your condition worse: _____

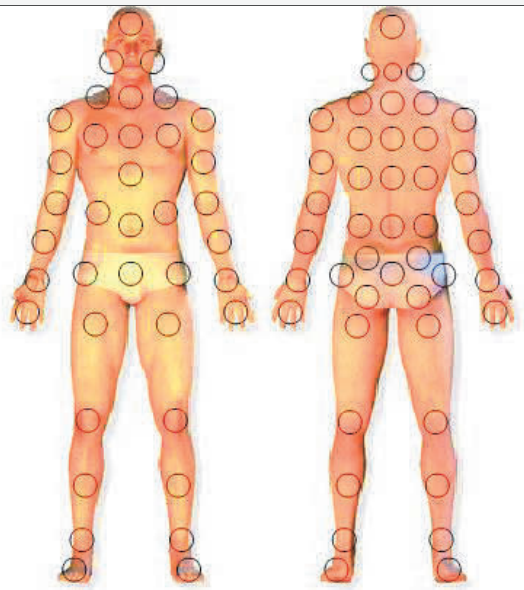
What makes your condition better: _____

How has your symptoms changed since the onset? ☐ Get Better ☐ Same ☐ Get Worse

Does your pain or symptoms wake you up at night? ❑ Yes ❑ No

Does your pain travel or radiate from one part of your body to the other? ❑ Yes ❑ No

By using the diagram below, please indicate on the body where you are experiencing your symptom



Have you applied Ice to the affected area? ❑ Yes ❑ No

Have you applied Heat to the affected area? ❑Yes ❑ No

Have you seen anyone else for this condition? ❑ Yes ❑ No

*If Yes Whom: _____

Additional Complaints or Information:

Please check corresponding boxes if YOU currently have or have had the condition in the past.
Please also indicate if your FAMILY history is affected by any of these conditions as well.
M = Mother F=Father S = Sister B=Brother C=Child

Cardiovascular:	Present	Past	Family History
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			
Other:_____			

Ears/Nose/Throat:	Present	Past	Family History
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

Eyes:	Present	Past	Family History
Glaucoma			
Double Vision			
Blurred Vision			

Musculoskeletal:	Present	Past	Family History
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			
Back Surgery			

Endocrine:	Present	Past	Family History
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			

Genitourinary:	Present	Past	Family History
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			
Other:_____			

Integumentary:	Present	Past	Family History
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			
Other:_____			

Psychiatric:	Present	Past	Family History
Depression			
Anxiety Disorder			
Unusual Stress			

Blood/Lymphatic:	Present	Past	Family History
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

Allergic/Immunologic:	Present	Past	Family History
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			
Other:_____			

Constitutional	Present	Past	Family History
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

Respiratory:	Present	Past	Family History
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			
TOBACCO USE			

Gastrointestinal:	Present	Past	Family History
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			

Neurologic:	Present	Past	Family History
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			