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):

_____

_____

What event or activity brought on your symptoms? _____

When did your symptoms start? / /

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 _____

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

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

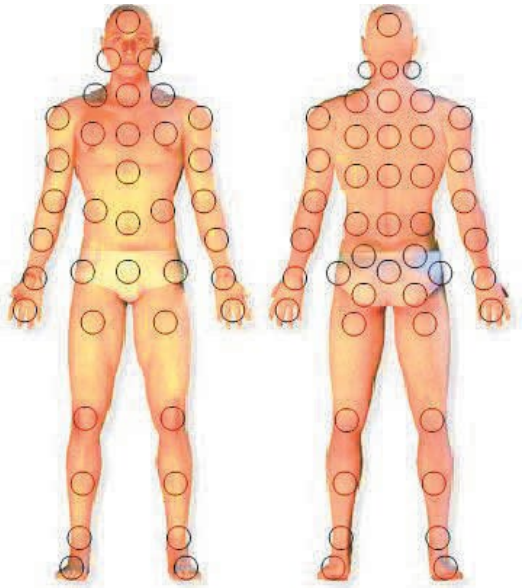
How has your condition changed since the onset: ☐ Stayed Same ☐ Better ☐ Worse

What makes your condition better: _____

What makes your condition worse: _____

Previous Episodes: ☐ 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: _____

Recent Diagnostic Tests: ☐Yes ☐ No _____

What activities of daily living are affected by your current Condition? _____

_____

How long are you able to do the activities before pain?

_____

How long do you need to do the activity?

_____

Review of Systems & Family History

Musculoskeletal:	Y	N
Osteoporosis		
Arthritis		
Joints Replaced		
Pins or Plates		
Previous Back Surgery		
Other _____		

Neurological:	Y	N
Dizziness		
Numbness		
Tingling		
Weak Muscles		
Progressive Neuro Diease		
Temporary Loss Vision		
Temporary Loss Smell		
Temporary Loss of Hearing		

Head & Ear Nose Throat:	Y	N
Headaches		
Ear Infections		
Difficulty Swallowing		
Sinus Issues		
Difficulty Hearing		

Cardiovascular:	Y	N
Blood Clotting disorder		
Chest Pain		
Heart Defect		
Heart Attack		
High Blood Pressure		
High Cholesterol		
Other _____		

Respiratory:	Y	N
Asthma		
Shortness of Breath		
Wheezing		
Pneumonia		
Persistent Cough		
Other _____		

Gastrointestinal:	Y	N
Abdominal Pain		
Change in Bowel Habits		
Crohn's		
Constipation		
Diarrhea		
Heartburn		
Other _____		

Genitourinary:	Y	N
Blood in urine		
incontinence		
kidney stones		
painful urination		
sexual dysfunction		

Endocrine:	Y	N
Diabetes		
Pancreatic Condition		
Excess Hot/Cold		
Excess Thirst		
Thyroid Disorder		

Dermatologic/Hemopoietic	Y	N
Blood in stool		
Easy Bruising		
Psoriasis		
Skin Cancer		
Rashes		

Allergy or Sensitivity:	Y	N
Latex		
Tree Nuts		
Seafood		
Tape or Adhesive		
Gluten		
Penicillin		
Sulfonamides		
Other _____		

Personal Past History

Surgery: _____

Medications: _____

Illnesses: _____

Accidents: _____

Family History		Y	N
Heart Disease			
Diabetes			
Stroke			
Hypertension			
Neurological Disorder			

Cancer: _____

Other: _____

Social History:		Y	N
Employment Status			
	FullTime		
	PartTime		
	Homemaker		
	Student		
	Retired		
Smoker			
Alcohol			
Recreational Drugs			

Women's Health:	Y	N
Currently Pregnant		
Currently Nursing		
Taking Birth Control		
Dysmenorrhea		
Irregular Periods		
Breast Implants		
Recent Breast Exam		
Hormone Replacement		
Recent Pap/Pelvic Exam		
Recent Mammogram		
Recent Vaccination		

Men's Health:	Y	N
Pain in Scrotum		
Impaired Libido		
Penile Discharge		
Prostate Problems		
Recent Prostate Exam		
Recent PSA test		
Recent Vaccination		