

DATE: _____

TI: _____

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State/Prov: _____ Zip Code: _____

Home Phone: () _____ Birth Date: _____ Age: _____ Sex: M F

Cell Phone: () _____ E-mail Address: _____

Social Security #: _____ Driver's License #: _____

Marital Status: Single Married Separated Divorced Widowed

Name of Spouse: _____ Spouse's Employer: _____

Name and Age of Children: _____

Who Is Responsible for your bill: You Spouse Workers' Comp. Auto Insurance Medicare
 Other _____

Your Occupation: _____ Employer: _____

Employer Phone: () _____

Insurance Company: _____ Group or Policy #: _____

Insured Person's Name: _____ Date of Birth: _____

Insured Person's Address if different from Patient: _____

Name and Number of Emergency Contact: _____

Relationship: _____

I hereby authorize the release of any and all medical information acquired in the course of my diagnosis and treatment.

(Signature of Patient or Guardian, if Minor)

CURRENT HEALTH CONDITION

Major Complaint: _____

Secondary Complaints: _____

Date of Onset: _____ Time of Onset: _____

Other Doctors Seen For This Condition: Yes No Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No

Is Condition: Job Related Auto Accident Home Injury Fall Other: _____

Have You Made A Report of Your Accident To Your Employer: Yes No

Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxants Blood Pressure Coumadin
 Insulin Other _____

Do You Wear A Shoe Lift or Orthotics? Yes No

Referred To This Office By: _____

PAST HEALTH HISTORY

NAME _____

Please Check and Describe: Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder
 Hernia Back Surgery Hysterectomy Other _____

Major Accidents or Falls: _____

Whiplash: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | INTAKE |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> * Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | <input type="checkbox"/> Energy Drinks |
- Have you been tested HIV positive? Yes No Other Diseases _____

PLEASE NUMBER THE FOLLOWING CONDITIONS YOU HAVE/HAD AS:

0) Never 1) Past 2) Present 3) Both-Past & Present

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Faulty Posture
- Painful Tailbone
- Spinal Curvature
- Neck Pain
- Neck Bone Spurs
- Arm/Shoulder Pain
- Joint Pain/Stiffness
- Walking Problems/Foot Pain
- Difficult Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM

- Nervous
- * Numbness
- Paralysis
- * Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

C-V-R

- Chest Pain
- Short Breathe
- Asthma
- * Blood Pressure Problems
- Irregular Heartbeat
- * Heart Problems
- Lung Problems
- Varicose Veins
- Ankle Swelling
- * Stroke
- Who? _____
- Age: _____

GENERAL CODE

- Loss of Sleep-(Get to Sleep/Stay Asleep)
- Fatigue- AM / PM / Both
- Allergies
- Fever
- Headaches
- Frequent Colds

EENT

- * Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Ear Discharge
- * Ringing in Ears
- * Hearing Difficulty
- Stuffed Nose

* Relates to George's Cerebrovascular Craniocervical Function Test

LLOYD E. NELSON D.C.
2899 10TH STREET
BAKER CITY, OR 97814
(541) 523-6565 FAX: (541) 523-6500

GENITO-URINARY

Bladder Trouble
 Painful/Excessive Urination
 Discolored Urine
 Other _____

MALES ONLY

Prostate
 Sexual Dysfunction
 Other Problems

FEMALES ONLY:

PMS
Date of Last Period _____
 Taken Oral Contraceptives
When _____
Are you Pregnant?
 Yes No Not Sure
 Menstrual Irregularity
 Menstrual Cramps
 Vaginal Pain/Infections
 Breast Pain/Lumps
 Other Problems

FAMILY HISTORY

Please list illnesses or conditions which your family members have or have had that concern you -i.e. arthritis, sleep disorders, chronic diseases, cancer etc.

Please list below:

Mother _____
 Father _____
 Brother _____
 Sister(s) _____
 Spouse _____
 Child(ren) _____

Most patients that come to our office have one of three objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as, the symptoms corrected and relieved (Corrective Care). Beyond corrective care, Dr. Nelson can help you with Wellness Care which helps maintain optimal health; but may not be covered by many insurance companies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care

Corrective Care

Check here if you want the
Doctor to select the type of care
appropriate for your condition

Wellness Care

By signing here I Authorize/Give consent for Dr. Nelson to treat my complaints with the form of care appropriate for my condition.

Date

Patient's Signature (PARENT OR GUARDIAN)

LLOYD E. NELSON DC
FAMILY WELLNESS CENTER
 2899 10TH ST. BAKER CITY, OR. 97814
 (541) 523-6565

PATIENT'S NAME _____ DATE _____

PATIENT'S DAILY PROGRESS REPORT / TREATMENT / SOAP NOTES

NOTE TO PATIENT: Insurance and Medicare require an area of complaint for payment. If you do not mark the area, even if it is treated, reimbursement by your insurer may be reduced! Please be complete.

Name your condition in the space below:

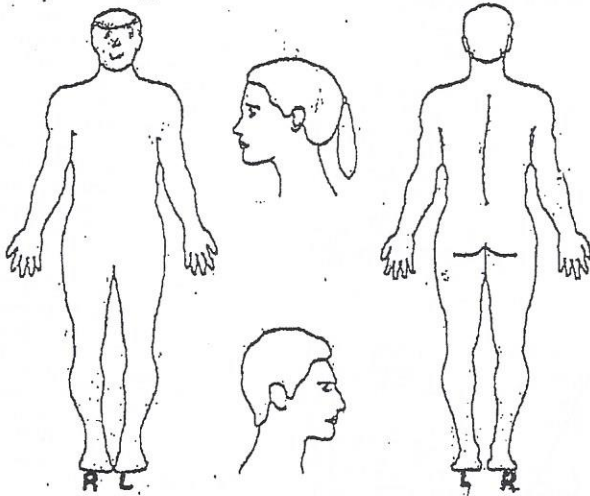
CHIEF COMPLAINT FIRST	NO PAIN	SEVERE PAIN	Compared to last visit
1. _____	0 1 2 3 4 5 6 7 8 9 10	New Better Same Worse	P _____ T _____ R _____
2. _____	0 1 2 3 4 5 6 7 8 9 10	New Better Same Worse	P _____ T _____ R _____
3. _____	0 1 2 3 4 5 6 7 8 9 10	New Better Same Worse	P _____ T _____ R _____
4. _____	0 1 2 3 4 5 6 7 8 9 10	New Better Same Worse	P _____ T _____ R _____
5. _____	0 1 2 3 4 5 6 7 8 9 10	New Better Same Worse	P _____ T _____ R _____

Place the number from the above Complaint (eg. 1, 2, or 3) onto the Drawing and then add a letter(s) describing the type of pain.

- A = Ache
- B = Burn
- S = Sharp
- T = Throb
- N = Numbness / tingling
- P = Pins & Needles

P - Provoking factors Stand, Walk, Sit, Lay Bend, Twist, Reach, ?
 T - Timing (O = occasional, I = intermittent C = constant) Radiating?

PATIENT'S OBSERVATIONS (ONSET OR CAUSE OF SYMPTOMS, WHAT INCREASES OR DECREASES PAIN)



PATIENT SIGNATURE _____
 PARENT OR GAURDIAN _____

Since your last visit Any NEW Conditions / accidents / injuries? Yes NO Note details in Patient's Observations above

Have you missed work? Yes No If yes, are you still off work? Yes No

Have you seen another doctor? Yes No Name? _____

DOCTOR'S NOTES Do not write below this line
