Dr. Julie Orman, DC

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Patient History

Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Cell Phone:** _____

Email Address _____

How did you hear about us: _____

Date of Birth: _____ **Age:** _____ **SS#:** _____

Occupation: _____ **Employer:** _____

Marital Status: _____

Children's Names/Ages: _____

Person responsible for this account: _____

What do you hope to receive from this office? _____

Reason for your visit: _____

Is this visit the result of a work injury or accident? Y N _____

Do you have a primary care physician? Y N **Name:** _____

Have you ever been to a chiropractor? Y N **Name:** _____

Do you have health insurance? Y N **Name:** _____

Insurance Carrier Name _____

Do you want us to verify your insurance benefits? Y N

Do you have any current health concerns? Please describe: _____

_____

Have you ever been diagnosed with any disease, and if so what? _____

_____

Please check any below that apply:

- ☐ Allergies
- ☐ Anxiety
- ☐ Cardiovascular concerns
- ☐ Depression
- ☐ Digestive problems
- ☐ Dizziness
- ☐ Fatigue
- ☐ Frequent illness
- ☐ Headaches
- ☐ Irritability
- ☐ Nervousness
- ☐ Numbness
- ☐ Painful menstruation
- ☐ Respiratory problems
- ☐ Ringing in the ears
- ☐ Sleep difficulties

Pain in the:

- ☐ Neck
- ☐ Upper back
- ☐ Middle back
- ☐ Lower back
- ☐ Shoulder
- ☐ Wrist/Hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle/Foot/ Lower legs

Other Symptoms: _____

_____

Are these symptoms worse from walking, standing, or climbing? **Y N**

Which of the above bothers you the most? _____

How long have you been bothered by this condition? _____

Describe how it feels or affects you when it is at its worst: _____

Does it cause you to be:

- ☐ Moody
- ☐ Irritable
- ☐ Sleep deprived
- ☐ Restricted in daily activities

Does it affect your work:

- ☐ Decision Making
- ☐ Create a poor attitude
- ☐ Decrease productivity
- ☐ Are you exhausted at day end?

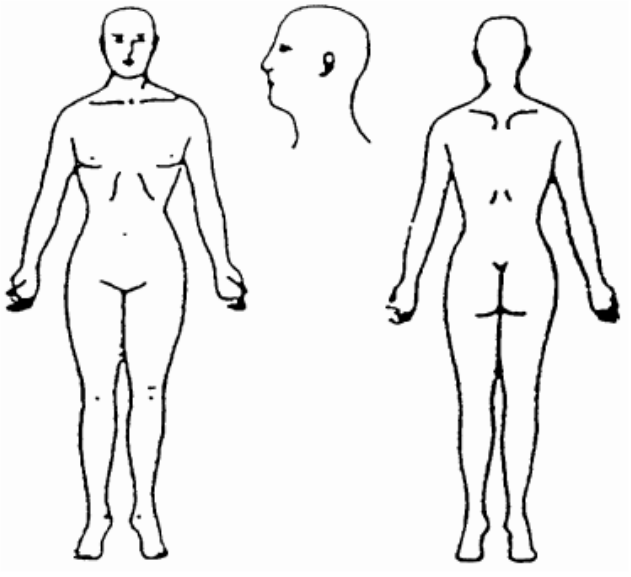
Does it cause you to:

- ☐ Lose patience with people
- ☐ Restrict household duties
- ☐ Hinder ability to exercise
- ☐ Interfere with your hobbies
- ☐ Avoid activities due to foot/leg pain

Subjective Pain Diagram ➔

- Please indicate your areas of pain on the diagram to the right.
- Mark the areas using the numbers shown below.
- Include all affected areas.

Low Pain	**1**	**2**	**3**
Moderate	**4**	**5**	**6**
Intense	**7**	**8**	**9**
Emergency	**10**		



History of Chemical Stress

Please list any drugs and your reason for taking them: _____

_____

Did you or do you work with any chemicals, fumes, dust, powder, smoke, etc?

_____

Do you or did you smoke? How much and for how long? _____

Do you consume any of the following? **D** = Daily **W** = Weekly **M** = Monthly **N** = None

D W M N **Alcohol**	D W M N **Artificial sweetener**	D W M N **Caffeine**
D W M N **Recreational drugs**	D W M N **Refined sugar**	D W M N **Soda**

History of Physical Stress

What are the activities you do regularly at work, home, or school?

☐ Sit ☐ Stand ☐ Walk ☐ Desk work ☐ Phone work ☐ Wear bifocals
☐ Sports ☐ Exercise ☐ Watch TV ☐ Physical labor ☐ Heavy lifting ☐ Mechanical work
☐ Prolonged driving ☐ Read for prolonged periods ☐ Play a musical instrument

What position do you sleep in? _____ ___

How much time do you spend at a computer each day (on average)? _____

How many hours per day do you spend on your cell phone? _____

Do you cradle the phone between your ear and shoulder? Y N

Birth Stress

Was your birth: ☐ Drug induced ☐ Forceps or Suction ☐ C-Section ☐ Traumatic

Falls *(Check all that apply)*

☐ Out of a tree ☐ Steps / stairs ☐ On ice
☐ Skiing ☐ Play structure ☐ Skateboarding
☐ Snowboarding ☐ Other _____

Other trauma *(Check all that apply)*

☐ Head injury / Knocked unconscious ☐ Broken bones ☐ Had an impact that may have injured your spine
☐ Involved in sports ☐ Extensive dental/orthodontia ☐ Physical fight / Abuse ☐ Used crutches/cane

☐ Other _____

Accidents and Near-Accidents *(Check all that apply and indicate severity)*

	Mild	Moderate	Severe
☐ Automobile		____	_____ _____
☐ Motorcycle	____	_____	_____
☐ Bicycle	____	_____	_____
☐ Other	____	_____	_____

Medical Intervention *(Check all that apply and age)*

☐ Hospitalization *why?* _____

☐ Surgery *what?* _____

☐ Chemotherapy _____ ☐ Radiation _____ ☐ Physical therapy _____ ☐ Casts/collars _____

☐ Spinal/neck brace _____ ☐ Corrective shoes, bars, lifts ☐ Spinal tap/injections

Comments: _____

History of Emotional Stress

Rate the severity of each stress, past or present: M = Mild Md = Moderate Sv = Severe

M	Md	Sv	Commuting	M	Md	Sv	Lifestyle change
M	Md	Sv	Stress of being sick	M	Md	Sv	Loss of a loved one
M	Md	Sv	School	M	Md	Sv	Illness of a loved one
M	Md	Sv	Work	M	Md	Sv	Childhood stress
M	Md	Sv	Abuse	M	Md	Sv	Parent's divorce
M	Md	Sv	Family	M	Md	Sv	Relationship stress
M	Md	Sv	Friends	M	Md	Sv	Divorce/separation
M	Md	Sv	Financial stress or job loss				

How do you rate your physical health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting better ☐ Getting worse

How do you rate your emotional/mental health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting better ☐ Getting worse

If you consider yourself ill, why do you feel you are ill? _____

If you consider yourself well, why do you feel you are well? _____

Is there anything else you would like to share which may help us to better understand you and why you have chosen to come to this office? _____

Authorization for Care of a Minor

I hereby authorize this office and its Doctors to administer care to my son / daughter as they deem necessary. I clearly understand and agree that I am personally responsible for all fees charges by this office.

Signed: _____ **Date:** _____ **Witnessed:** _____