Fogarty
Chiropractic Life Clinic

LASTING PURPOSE

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Please fill in below:

Name:_____ Date:_____

Address:_____ Apt:_____ City, State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Gender: M___ F___ Date of Birth:_____ Height:_____ Weight:_____

Marital Status: _____ SS#:_____ Email:_____

Chief Complaint:_____

Mechanism of Injury: _____

_____

How long have you had this problem?_____

Are you under the care of any other physician? Yes_____ No_____

If yes, please list the doctors you are seeing and the conditions you are being treated for:

_____

_____

Please list any medication you are presently taking and the reason for taking it:

_____

_____

Please list any previous surgeries: _____

_____

Please list any accidents, auto accidents, or broken bones in the past:_____

_____

Please list previous imaging: _____

Have you been to a chiropractor before? Yes_____ No _____ Date of last visit:_____

How long were you under care?_____ Condition treated for:_____

Name of chiropractor: _____

Your occupation:_____

Duties you are required to perform regularly at work or home: _____

_____

Do you smoke cigarettes? Yes_____ No_____ # of packs per day:_____

Do you drink coffee? Yes____ No_____ # of cups per day:_____

Do you consume alcohol? Yes____ No_____ Approximately how much daily? _____

Do you exercise regularly? Yes____ No_____ What type and how much?_____

Family Health History

Please describe the health of your:

Father: _____ Mother: _____

Spouse: _____ Children, give ages: _____

FEMALES: Is there a possibility of you being pregnant? _____

Have you EVER had any of the following? Please check:

___ Hay Fever	___ Prostate Problems	___ Heart Disease	___ Venereal Disease	___ Ulcers
___ T.B.	___ Gout	___ Thyroid Trouble	___ Hemorrhoids	___ Epilepsy/Seizures
___ Allergies	___ Pneumonia	___ Cancer	___ Tonsillitis	___ Liver Trouble
___ Polio	___ Pleurisy	___ Gall Bladder Trouble	___ Appendicitis	___ Diabetes
___ Slipped Disc	___ Asthma	___ High Blood Pressure	___ Arthritis	___ Rheumatic Fever
___ Stroke	___ Bowel Trouble	___ Menstrual Problems	___ Hypoglycemia	___ Kidney Trouble

Other: _____

Systems Review

Are you PRESENTLY suffering from any of the following? Please check:

Eyes
___ change in vision
___ eye pain
___watery eyes

Ears
___ ear discharge
___ impaired hearing
___ ear aches
___ ringing in ears

Nose
___ sinus pains
___ nose bleeds

Throat
___ blisters in mouth
___ problems swallowing
___ throat lumps
___ sore throat

Cardiovascular
___ heart palpitations
___ chest pains

Abdominal
___ indigestion
___ heart burn
___ belching
___ vomiting
___ rectal bleeding
___ irritable bowel
___ gas
___ constipation
___ diarrhea
___ abdominal pains
___ nausea
___ change in weight
___ swelling

Musculoskeletal
___ back pains
___ hip pains
___ leg pains
___ neck pains
___ shoulder/arm pains
___ other muscle pains
___ numbness
___ tingling
___ joint pains
___ swelling of ankles
___ swelling of joints

Neurological
___ headaches
___ balance issues
___ fatigue
___ weakness

Cognitive
___ poor appetite
___ poor memory
___ insomnia
___ inner tension
___ nervousness
___ personality changes

Pulmonary
___ cough
___ shortness of breath
___ dizziness
___ fainting

Urinary
___ blood in urine
___ frequency of urination
___ pain on voiding
___ cloudy urine

Skin
___ dry skin
___ skin discoloration
___ itching
___ burning
___ skin eruptions/rash
___ excessive sweating
___ bruising

Other *(please list)*
_____
_____
_____
_____
_____
_____
_____
_____

Insurance Information

Type of insurance: Regular Medical_____ Medicare____ Medicaid____ Auto_____ Workers Comp_____
Name of Insured: _____ SS# _____
Insured's Date of Birth: _____ Name of Employer: _____
Insurance Company: _____ Phone #: _____
Insurance Company Address: _____
Policy # _____ Group # _____ Claim # _____

I certify to the best of my knowledge, the above information is complete and accurate. I agree to notify this practitioner immediately whenever I have changes in my health condition.

Patient Name: _____ Date: _____

Signature: _____ Relation to patient: _____