Mahaska Chiropractic

Patient Health History

Today's Date / / Signature of Patient _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ Nick Name_____

Last Name _____ Middle Name _____Suffix _____

Address 1 _____

Address 2 _____

City_____ State_____ Zip Code _____

Primary Phone _____ Place of Employment _____

Mobile Phone _____

Home email _____ Work Phone _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

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

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other SSN _____

Employment Status *(check one)*

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

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Continued ...

MAHASKA CHIROPRACTIC
301 N. 1st Street, Ste. B
Oskaloosa, IA 52577
Phone: 641-673-8414

Emergency Contact_____PHONE_____

Referred by:_____

What is your major complaint?_____

Is this problem due to either a work or car accident? ____yes ____No
(if so we will need extended info on who to bill)

Other complaints_____

How long have you had this condition?_____Have you had this condition in the past?_____

Is this condition getting progressively worse? ____Yes ____No ____Constant _____Comes and goes

This is a new / old illness. It was / was not treated before.
If treated before, what was done?_____

Have you ever had surgery or been hospitalized Yes / No
List surgeries _____

Have you ever had Chiropractic Care before? Yes / No
Name of Doctor. _____

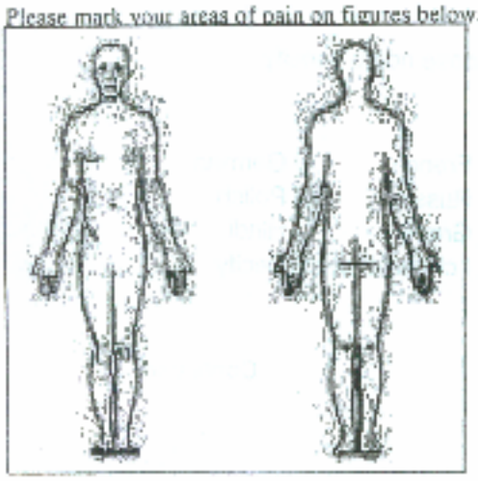
Last time you had spinal X-Rays or MRI'S_____

Female: Are you pregnant at this time? Yes / No
Due Date:_____LMP Date:_____

From birth to present please list by date / describe

1.) Car Accidents _____
2.) Falls / Injuries (including sports)
_____
3.) Other
_____

Please mark your areas of pain on figures below.



____Neck Problems
____Shoulder Problems
____Arm Problems
____Numboess-Arms
____Pain Between shoulders
____Low Back Problems
____Leg Problems
____Numbness-Legs
____Loss of Feeling
____Stiff Joints
____Painful Joints
____Restricts Daily Activities
____Restricts Regular Exercise
____ Frequent Colds

____Sore Muscles
____Walking Problems
____Broken Bones
____Muscle Cramps
____Weak Muscles
____Headaches
____Dizziness
____Fainting
____Forgetfulness
____Depression
____Vision Problems
____Ear Pain / Noises
____Hearing Loss
____Ear Infections
____Tiredness / Fatigue

____Allergies
____Hay Fever
____Asthma
____Eczema
____Shingles
____Nausea
____Poor Digestion
____Ulcers
____Diarrhea
____Constipation
____Kidney Infections
____Menstrual Cramps
____Diabetes
____Blood Pressure
High / Low