CONFIDENTIAL HEALTH INFORMATION

Lockport Chiropractic
Dr. Timothy Radcliffe
360 Summit Drive
Lockport, IL 60441
(815) 838-9441

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.

Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
◯ No ◯ Yes When?

Whom may we thank for referring you?

If so, whom?

Gender
◯ Male ◯ Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status
◯ Single ◯ Married ◯ Divorced
◯ Widowed ◯ Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?
◯ Yes ◯ No

Preferred method of contact?
◯ Home Phone ◯ Cell Phone
◯ Work Phone ◯ Email

Address

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?
◯ Self ◯ Spouse ◯ Parent

First Name

Middle Name (or Initial)

Nationality/Race:(check one) □White/Caucasian □ Black/African American □ Hispanic/Latino □ Chinese
□ Japanese □Other:_____
□I choose not to specify

Multi-Racial: (check one) □ Yes □ No □Unknown

Preferred Language: (check one) □English □ Spanish
□Chinese □Japanese □American Sign Language
Other:_____

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. When did they start? Please explain how it occurred. _____

_____

_____

_____

3. And are the result of (darken circle):

- ◯ An accident or injury
  - ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

4. Onset (When did you first notice your current symptoms?)

_____

5. Intensity (How extreme are your current symptoms?)

0 ⓪ ○ ○ ○ ○ ○ ○ ○ ○ ○ ⑩ 10

Absent Uncomfortable Agonizing

6. Duration and Timing (When did it start and how often do you feel it?)

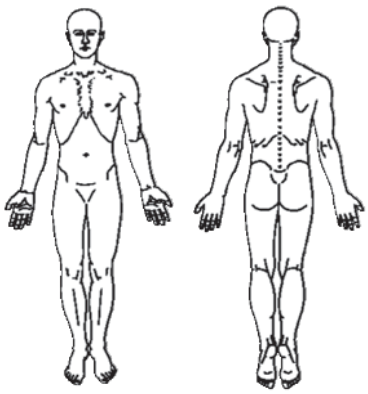
◯ Constant ◯ Comes and goes. How Often? _____

_____

7. Quality of symptoms (What does it feel like?)

- ◯ Numbness
- ◯ Tingling
- ◯ Stiffness
- ◯ Dull
- ◯ Aching
- ◯ Cramps
- ◯ Nagging
- ◯ Sharp
- ◯ Burning
- ◯ Shooting
- ◯ Throbbing
- ◯ Stabbing
- ◯ Other _____

8. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



9. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

10. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

11. Prior interventions (What have you done to relieve the symptoms?)

- ◯ Prescription medication ◯ Surgery ◯ Ice
- ◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
- ◯ Homeopathic remedies ◯ Chiropractic Other _____
- ◯ Physical therapy ◯ Massage _____

12. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture

NONE ◯ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness

NONE ◯ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising

NONE ◯ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia

NONE ◯ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea

NONE ◯ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste

NONE ◯ Initials ____

g. Integumentary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash

NONE ◯ Initials ____

Consultation Notes

Patient name _____

Doctor's Initials _____

Lockport Chiropractic
Dr. Timothy Radcliffe

(Continued from previous page)

h. Endocrine

Had Have ○ ○ Thyroid issues | Had Have ○ ○ Immune disorders | Had Have ○ ○ Hypoglycemia | Had Have ○ ○ Frequent infection | Had Have ○ ○ Swollen glands | Had Have ○ ○ Low energy | NONE ○ Initials ____

i. Genitourinary

Had Have ○ ○ Kidney stones | Had Have ○ ○ Infertility | Had Have ○ ○ Bedwetting | Had Have ○ ○ Prostate issues | Had Have ○ ○ Erectile dysfunction | Had Have ○ ○ PMS symptoms | NONE ○ Initials ____

j. Constitutional

Had Have ○ ○ Fainting | Had Have ○ ○ Low libido | Had Have ○ ○ Poor appetite | Had Have ○ ○ Fatigue | Had Have ○ ○ Sudden weight gain/loss (circle one) | Had Have ○ ○ Weakness | NONE ○ Initials ____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

13. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	
○	○	Alcoholism	○	○	Tuberculosis
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Seasonal Allergies_____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

14. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

15. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: _____

16. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing

Consultation Notes

17. Family History

Some health issues are hereditary. Tell Dr. Radcliffe about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health Good	Poor	Illnesses	Age at death	Cause of death Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister		○	○			○	○
Sister		○	○			○	○
Brother		○	○			○	○
Brother		○	○			○	○
		○	○			○	○

18. Are there any other hereditary health issues that you know about? _____

19. Social History

Tell Dr. Radcliffe about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much?_____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much?_____	Job pressure/stress?	○ Yes	○ No
Water Intake	○ Daily	○ Weekly	How much?_____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much?_____	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much?_____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much?_____	Recreational drugs?	○ Yes	○ No

Hobbies: _____

Patient name

Doctor's Initials

Lockport Chiropractic
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20. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

21. What is the major stressor in your life? _____ 22. How much sleep do you average per night? _____ Hours

23. What is the type and approximate age of your mattress and pillow? _____ 24. What is your preferred sleeping position? _____

25. Describe your typical eating habits: ◯ Skip breakfast ◯ Two meals a day ◯ Three meals a day ◯ Snacking between meals

26. What would be the most significant thing that you could do to improve your health? _____

27. In addition to the main reason for your visit today, what additional health goals do you have? _____

28. I realize that an X-Ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.
Date of last menstrual period (MM/DD/YYYY) _____

29. Do you currently use tobacco of any kind? (check one) □ Yes □ Never been a smoker □ Former smoker
If yes, how often do you use tobacco and what kind: □ Cigarettes/Cigars □ Smokeless tobacco
□ Current everyday □ Current occasional

30. Please list any known Medication Allergies: _____

□ No known allergies

31. Please list any current medications _____

□ No current medications

32. Approximate Date of last Mammogram (women age 40 – 69 only) _____

33. Have you ever received a Pneumonia Vaccination (Over 65 only) _____

For Treatment of Minor Child Only

If the patient is a minor child, print child's full name:

I hereby authorize Timothy E. Radcliffe, D. C. and whomever he may designate as his assistants to Administer treatment, as he so deems necessary to my child:

Responsible Party
Name
Relationship to child
Address
Phone Number
Social Security Number of Responsible Party

Parent or Guardian Signature _____ Date (MM/DD/YYYY) _____

Patient name _____

Consultation Notes

Doctor's Initial
Lockport Chiropractic
Dr. Timothy Radcliffe