

CONFIDENTIAL HEALTH INFORMATION

Bear River Chiropractic
Dr. James McCrie, DC, CCSP
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Bearriverchiropractic.com

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? <input type="radio"/> No <input type="radio"/> Yes		Patient Number (office use only)	
Whom may we thank for referring you?		When?		If so, whom?	
Age	Gender <input type="radio"/> Male <input type="radio"/> Female	Race <input type="radio"/> American Indian <input type="radio"/> Alaskan Native <input type="radio"/> Asian <input type="radio"/> Black or African American <input type="radio"/> Native Hawaiian <input type="radio"/> Other Pacific Islander <input type="radio"/> Other <input type="radio"/> White <input type="radio"/> Decline to answer		Ethnicity <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Decline to specify	
Birth Date (MM/DD/YYYY)		Your Last Name		Your Social Security Number	
Your First Name		Your Middle Name (or Initial)		Smoking Status (age 13 and over) <input type="radio"/> Never A Smoker <input type="radio"/> Former Smoker <input type="radio"/> Current Every Day Smoker <input type="radio"/> Current Some Day Smoker <input type="radio"/> Heavy Smoker <input type="radio"/> Light Smoker	
Address		Marital Status <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Separated		Preferred Language	
City	State/Province	ZIP/Postal Code			
Home Phone	Cell Phone	Spouse's Name			
Email Address	Emergency Contact		Emergency Contact's Phone		Child's Name and Age
Your Occupation	Your Employer		Address		Child's Name and Age
Your Employer		Address		Work Phone	
City		State/Province		ZIP/Postal Code	
Primary Care Provider's Name		May we contact you at work? <input type="radio"/> Yes <input type="radio"/> No		Preferred method of contact? <input type="radio"/> Home Phone <input type="radio"/> Cell Phone <input type="radio"/> Work Phone <input type="radio"/> Email	
Insurance Carrier		Policy Number		Who carries this policy? <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Parent	
Insured's Last Name		Birth Date (MM/DD/YYYY)			
Insured's First Name		Insured's Middle Name (or Initial)			
Insured's Employer		Address			
City		State/Province		ZIP/Postal Code	
Employer's Phone					

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

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

Primary Complaint
The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
 An accident or injury
 Work Auto Other _____

A worsening long-term problem
 An interest in: Wellness Other _____

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

Prior interventions (What have you done to relieve the symptoms?)
 Prescription medication Acupuncture
 Over-the-counter drugs Chiropractic
 Homeopathic remedies Massage
 Physical therapy Ice
 Surgery Heat
 Other _____

Secondary Complaint
The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
 An accident or injury
 Work Auto Other _____

A worsening long-term problem
 An interest in: Wellness Other _____

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

Prior interventions (What have you done to relieve the symptoms?)
 Prescription medication Acupuncture
 Over-the-counter drugs Chiropractic
 Homeopathic remedies Massage
 Physical therapy Ice
 Surgery Heat
 Other _____

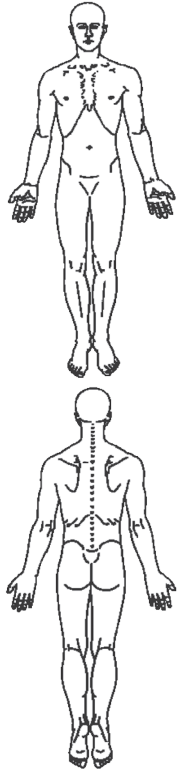
Additional Complaint
The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
 An accident or injury
 Work Auto Other _____

A worsening long-term problem
 An interest in: Wellness Other _____

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

Prior interventions (What have you done to relieve the symptoms?)
 Prescription medication Acupuncture
 Over-the-counter drugs Chiropractic
 Homeopathic remedies Massage
 Physical therapy Ice
 Surgery Heat
 Other _____



1. What else should Dr. McCririe know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. 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 <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Osteoporosis	<input type="radio"/> Arthritis	<input type="radio"/> Scoliosis	<input type="radio"/> Neck pain	<input type="radio"/> Back problems	<input type="radio"/> Hip disorders	Initials _____
<input type="radio"/> Knee injuries	<input type="radio"/> Foot/ankle pain	<input type="radio"/> Shoulder problems	<input type="radio"/> Elbow/wrist pain	<input type="radio"/> TMJ issues	<input type="radio"/> Poor posture	

b. Neurological

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Anxiety	<input type="radio"/> Depression	<input type="radio"/> Headache	<input type="radio"/> Dizziness	<input type="radio"/> Pins and needles	<input type="radio"/> Numbness	Initials _____

c. Cardiovascular

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> High blood pressure	<input type="radio"/> Low blood pressure	<input type="radio"/> High cholesterol	<input type="radio"/> Poor circulation	<input type="radio"/> Angina	<input type="radio"/> Excessive bruising	Initials _____

d. Respiratory

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Asthma	<input type="radio"/> Apnea	<input type="radio"/> Emphysema	<input type="radio"/> Hay fever	<input type="radio"/> Shortness of breath	<input type="radio"/> Pneumonia	Initials _____

e. Digestive

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Anorexia/bulimia	<input type="radio"/> Ulcer	<input type="radio"/> Food sensitivities	<input type="radio"/> Heartburn	<input type="radio"/> Constipation	<input type="radio"/> Diarrhea	Initials _____

f. Sensory

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Blurred vision	<input type="radio"/> Ringing in ears	<input type="radio"/> Hearing loss	<input type="radio"/> Chronic ear infection	<input type="radio"/> Loss of smell	<input type="radio"/> Loss of taste	Initials _____

g. Skin

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Skin cancer	<input type="radio"/> Psoriasis	<input type="radio"/> Eczema	<input type="radio"/> Acne	<input type="radio"/> Hair loss	<input type="radio"/> Rash	Initials _____

Patient name

Patient Number
(office use only)

Doctor's Initials

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(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 _____

Patient name _____

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 _____

Patient Number (office use only) _____

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 _____

All other systems negative

Past Personal, Family and Social History

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

PERSONAL	4. Illnesses Check the illnesses you have Had in the past or Have now.	5. Operations Surgical interventions, which may or may not have included hospitalization.	6. Treatments Check the ones you've received in the Past or are receiving Currently .
	Had <input type="radio"/> Have <input type="radio"/> AIDS	Had <input type="radio"/> Have <input type="radio"/> Tuberculosis	Past <input type="radio"/> Currently <input type="radio"/> Acupuncture
	Had <input type="radio"/> Have <input type="radio"/> Alcoholism	Had <input type="radio"/> Have <input type="radio"/> Typhoid fever	<input type="radio"/> Antibiotics
	Had <input type="radio"/> Have <input type="radio"/> Allergies	Had <input type="radio"/> Have <input type="radio"/> Ulcer	<input type="radio"/> Birth control pills
	Had <input type="radio"/> Have <input type="radio"/> Arteriosclerosis	Had <input type="radio"/> Have <input type="radio"/> Other: _____	<input type="radio"/> Blood transfusions
	Had <input type="radio"/> Have <input type="radio"/> Cancer		<input type="radio"/> Chemotherapy
	Had <input type="radio"/> Have <input type="radio"/> Chicken pox		<input type="radio"/> Chiropractic care
	Had <input type="radio"/> Have <input type="radio"/> Diabetes	7. Allergies Are you allergic to any medications?	<input type="radio"/> Dialysis
	Had <input type="radio"/> Have <input type="radio"/> Epilepsy	Yes <input type="radio"/> No <input type="radio"/> If Yes please list: _____	<input type="radio"/> Herbs
	Had <input type="radio"/> Have <input type="radio"/> Glaucoma		<input type="radio"/> Homeopathy
	Had <input type="radio"/> Have <input type="radio"/> Goiter		<input type="radio"/> Hormone replacement
	Had <input type="radio"/> Have <input type="radio"/> Gout		<input type="radio"/> Inhaler
	Had <input type="radio"/> Have <input type="radio"/> Heart disease		<input type="radio"/> Massage therapy
	Had <input type="radio"/> Have <input type="radio"/> Hepatitis		<input type="radio"/> Physical therapy
	Had <input type="radio"/> Have <input type="radio"/> HIV Positive		<input type="radio"/> Medications
Had <input type="radio"/> Have <input type="radio"/> Malaria		(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): _____	
Had <input type="radio"/> Have <input type="radio"/> Measles			
Had <input type="radio"/> Have <input type="radio"/> Multiple Sclerosis			
Had <input type="radio"/> Have <input type="radio"/> Mumps			
Had <input type="radio"/> Have <input type="radio"/> Polio	8. Injuries Have you ever...		
Had <input type="radio"/> Have <input type="radio"/> Rheumatic fever	<input type="radio"/> Had a fractured or broken bone	<input type="radio"/> Used a crutch or other support	
Had <input type="radio"/> Have <input type="radio"/> Scarlet fever	<input type="radio"/> Had a spine or nerve disorder	<input type="radio"/> Used neck or back bracing	
Had <input type="radio"/> Have <input type="radio"/> Sexually transmitted disease	<input type="radio"/> Been knocked unconscious	<input type="radio"/> Received a tattoo	
Had <input type="radio"/> Have <input type="radio"/> Stroke	<input type="radio"/> Been injured in an accident	<input type="radio"/> Had a body piercing	

Consultation Notes

9. Family History

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

FAMILY	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
			<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>
	Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	_____	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

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

11. Social History

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

SOCIAL	Alcohol use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes <input type="radio"/> No
	Coffee use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes <input type="radio"/> No
	Tobacco use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes <input type="radio"/> No
	Exercising	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes <input type="radio"/> No
	Pain relievers	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes <input type="radio"/> No
	Soft drinks	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No
	Water intake	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____		
	Hobbies:	_____			

Doctor's Initials _____

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12. 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name _____

Patient Number
(office use only)

13. What is the major stressor in your life? _____ 14. How much sleep do you average per night? _____ Hours

15. What is the type and approximate age of your mattress and pillow? _____ 16. What is your preferred sleeping position? _____

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

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

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

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials _____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **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): _____**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Consultation Notes

Doctor's Initials _____

Bear River Chiropractic
Dr. James McCririe, DC, CCSP

Patient (or Guardian's) signature

Date (MM/DD/YYYY)