Headache & Pain Relief at Last!™

Confidential Health Information

Name: _____

Address: _____

City, State, Zip: _____

Birth Date: _____ **Home Phone:** _____

Cell Phone: _____ **Work Phone:** _____

E-mail address: _____
(important since we communicate periodically via email)

Marital Status: ☐M ☐W ☐D ☐S **Occupation:** _____

Your Employer: _____

Spouse's Name: _____

Spouse's Employer: _____

# of Children and Ages: _____

Method of Payment: ☐Cash ☐Check ☐Insurance ☐Credit/Debit ☐Accident/Injury

Who may we thank for referring you? _____

What made you decide to visit our office today?

_____

_____

What is the primary condition that you'd like to discuss today?

_____

_____

What started these symptoms?

_____

_____

When your symptoms are at their worst, how does this affect your normal, everyday activities (work, time with family, leisure activities)?

_____

_____

What tests have been performed to pinpoint the true cause of these symptoms?

_____

_____

What were the results of these tests?

_____

_____

What kind(s) of treatment have you tried for your condition?

_____

_____

What results did you get with this treatment?

_____

_____

What have you been told is the real, true cause of your symptoms?

_____

_____

What do YOU believe is the real, true cause of your symptoms?

_____

_____

Who is your Primary Care Physician: _____

City: _____ Phone: _____

Health History

Some of the following conditions have been related to spinal disorders. Please check any of the following conditions that you have or have had in the past:

☐ Allergies	☐ Gout	☐ Miscarriage	☐ Rheumatoid Arthritis
☐ Anemia	☐ Headaches/Migraines	☐ Multiple Sclerosis	☐ Rheumatic Fever
☐ Arthritis	☐ Heart Disease	☐ Numbness/Tingling	☐ Seizures
☐ Asthma	☐ Hepatitis	☐ Osteoporosis	☐ Shingles
☐ Bleeding Disorders	☐ Hernia	☐ Pacemaker	☐ Stroke
☐ Cancer	☐ Herniated Disc	☐ Parkinson's Disease	☐ Thyroid Problem
☐ Carpal Tunnel	☐ High Blood Pressure	☐ Pinched Nerve	☐ TMJ
☐ Diabetes	☐ High Cholesterol	☐ Polio	☐ Tuberculosis
☐ Epilepsy	☐ Kidney Disease	☐ Prostate Problem	☐ Tumors/Growths
☐ Fibromyalgia	☐ Liver Disease	☐ Prosthesis	☐ Ulcers

Other: _____

Exercise

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits

- ☐ Smoking ____Packs/Day
- ☐ Alcohol ____Drinks/Week
- ☐ Coffee/Caffeine ____Cups/Day
- ☐ Soda Pop ____Cans/Day

Accidents, Injuries or Surgeries you've had include:

	Date
Auto Accidents _____	_____
Falls _____	_____
Head Injuries _____	_____
Broken Bones _____	_____
Dislocations _____	_____
Surgeries _____	_____
_____	_____

Ladies, is there any chance of pregnancy? _____

Prescription Medications you're taking and their intended purpose:

_____
_____
_____
_____

Over the Counter Medications you're taking and how often:

_____
_____
_____

Vitamins, Minerals or Herbal Supplements you're taking:

_____
_____
_____
_____

My signature below authorizes "Dr. Scott" Chorny and Headache Relief at Last, as well as any designated staff, to evaluate and treat my condition or, if applicable, my child, as deemed necessary. All personal and health information contained herein is true and accurate.

Signature: _____ **Date:** _____

Insurance Information

Patient's Name: _____

Patient's Date of Birth: _____

Primary Policy Holder's Name: _____

Primary Policy Holder's Date of Birth: _____

Name of Insurance Company: _____

Insurance ID#: _____

Group #: _____

"Provider" or "Customer Service" Phone Number: _____

Do you have a "Flex Plan" or Health Savings Account to help with out of pocket healthcare expenses? _____