apple healthcare

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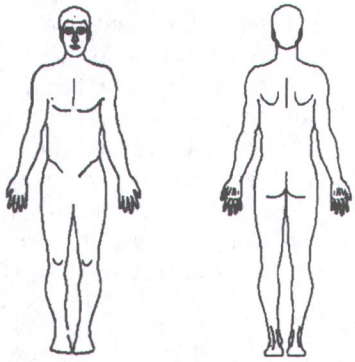
Patient Name: _____ Nickname: _____ Birthdate: _____
Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____
Home#: _____ Cell#: _____ Work#: _____
Occupation: _____ Employer: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Marital Status: ☐ M ☐ S ☐ W ☐ D Spouse Name: _____ Spouse's Occupation: _____
Do you have children? ☐ Y ☐ N How many? _____ Preferred Language: ☐ English ☐ Other: _____
Race: ☐ White ☐ Black/African American ☐ American Indian ☐ Asian ☐ Hispanic/Latino ☐ Multi-Racial ☐ Other Race
Referred By: ☐ Patient/Doctor _____ ☐ Event ☐ Radio/TV ☐ Print Media ☐ Insurance ☐ Internet
Emergency Contact: _____ Emergency Phone Number: _____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain ☐ Other _____
Is this? ☐ Work Related ☐ Auto Related ☐ N/A Date Problem Began: _____

Mark an X on the picture where you have pain



Current Complaint (how you feel today): 0 = No Pain 10 = Unbearable Pain

0 1 2 3 4 5 6 7 8 9 10

How often are your symptoms present? (Occasional) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

In general how is your overall health right now: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever/Rheumatic Fever
☐ Diabetes
☐ High ☐ Low Blood Pressure
☐ Blood Clots/Stroke (Date): _____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting/Concussion
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain) _____
☐ Osteoporosis/Arthritis
☐ Epilepsy/Seizures/Convulsions
☐ Other Health Problems (Explain) _____
☐ Prostate Problems
☐ Menstrual Problems/Hormones
☐ Thyroid ☐ Hyper ☐ Hypo
☐ Urinary Problems/Kidneys/Bladder
☐ Currently Pregnant, # Weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Sinus Trouble
☐ Anemia
☐ Back Pain Sciatica
☐ Digestion Problems
☐ Heart
☐ Lungs/Asthma/Bronchial
☐ Shortness of Breath
☐ Fibromyalgia
☐ Gout
☐ Skin
☐ Headaches
☐ Hand or Wrist Pain
☐ HIV/Aids/Blood Infections
☐ Bleeding Disorders
☐ Psychological Problems
☐ Neck Pain or spasms
☐ Neuritis/Numbness/Neuro Disorders
☐ M.S./Muscular dystrophy
☐ Venereal Disease
☐ Liver/Hepatitis/Cirrhosis
☐ Deep Vein Thrombosis
☐ Surgeries: _____

Have you seen a chiropractor this year? ☐ **Yes** ☐ **No** If yes, who? _____ How many visits? _____
Are you currently being treated under home health care? ☐ **Yes** ☐ **No** If yes, who? _____

Family Medical Doctor: _____ Date of Last Visit: _____M _____D _____Y

Family History (Mother/Father/Brother/Sister) please check/circle all of the following that apply to you:

☐ Heart Disease-M / F / B / S ☐ High Blood Pressure- M / F / B / S ☐ Diabetes- M / F / B / S ☐ Circulation Problems- M / F / B / S
☐ Cancer-M / F / B / S ☐ Rheumatoid Arthritis/Arthritis-M / F / B / S ☐ Stroke-M / F / B / S ☐ Neurological Disorder-M / F / B / S

Smoking Status: ☐ Current every day smoker ☐ Occasional smoker ☐ Former Smoker ☐ Never Smoked

ALLERGIES (please describe reaction such as hives, throat swelling, GI upset)	**Immunization Record** (list date of last vaccination)	
Allergic to: ☐ Antibiotic ☐ Tape ☐ Betadine (Iodine) ☐ Latex	Flu	Hepatitis
☐ Allergies to Medications (please list):	Pneumonia	Tetanus
☐ No Known Allergies	Other:	

Patient Signature: _____ **Date:** _____