BY APPOINTMENT

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NEELY'S MILL
1412 TROTWOOD AVENUE, SUITE 14
COLUMBIA, TENNESSEE 38401

ERIC D. SCHEITEL, D.C.

NAME--------------------------------------------------DATE------------------------------

**1.** HISTORY OF CANCER:

A: PERSONAL: NO-------- YES-------- (EXPLAIN)-------------------------------
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B: FAMILY: NO-------- YES--------- (EXPLAIN)--------------------------------
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**2.** ANY UNEXPLAINED WEIGHT LOSS? NO------- YES-------
**3.** HISTORY OF URINARY INFECTION? NO------- YES-------
**4.** PAIN INCREASED BY REST? NO------- YES-------
**5.** PAIN THAT WAKES YOU UP AT NIGHT? NO------- YES------- (EXPLAIN)------
-------------------------------------------------------------------------------------------
**6.** INTRAVENOUS DRUG USE? NO------- YES-------
**7.** PRESENCE OF FEVER IN (LAST 7-14 DAYS)? NO------- YES-------
**8.** BLADDER DYSFUNCTION:
A. PROBLEM WITH DECREASE IN URINE FLOW? NO------- YES-------
B. INABILITY TO HOLD URINE? NO------- YES-------
C. BEDWETTING? NO------- YES-------
D. BLOOD IN URINE? NO------- YES-------
E. PUS IN URINE? NO------- YES-------
F. PAIN WHILE URINATING? NO------- YES-------
G. BURNING WHILE URINATING? NO------- YES-------
H. FREQUENT URINATION? NO------- YES-------
I. NIGHT URINATION? NO------- YES-------
J. FREQUENT NEED TO URINATE, BUT UNABLE TO DO SO? NO---- YES----

# COLUMBIA CHIROPRACTIC HEALTH CENTER

**PATIENT NAME:**______________________________________ **DATE:**________________

**ALL PATIENTS MUST COMPLETE THIS FORM**

1.WHERE, EXACTLY IS THE PAIN? SEE ATTACHED BODY SHEET.
2. WHEN DID THE PAIN FIRST OCCUR? DATE___________

WAS THE ONSET GRADUAL OR SUDDEN? GRADUAL/SUDDEN
WAS AN INJURY (i.e. FALL,AUTO,WORK,ETC.) OR UNUSUAL ACTIVITY INVOLVED?
(i.e. MOVING,EXERCISING,LIFTING,ETC.)

3. WHAT IS THE QUALITY OF THE PAIN? (SHARP,DULL,BURNING,TINGLING,ACHING, BORING,EXCRUCIATING)

**PICK FROM THE FOLLOWING CHOICES AND CIRCLE ONE THAT MOST CLOSELY DESCRIBES YOUR CONDITION AT THIS TIME.**

**INTENSITY:**

**A.** MINIMAL - THIS IS WHEN YOUR PAIN IS ANNOYING BUT CAUSES NO IMPAIRMENT IN THE PERFORMANCE OF ANY PARTICULAR ACTIVITY.

**B.** SLIGHT - THIS IS WHEN YOUR PAIN CAN BE TOLERATED BUT CAN CAUSE SOME DIFFICULTY IN THE PERFORMANCE OF THE ACTIVITY THAT AGGRAVATES YOUR PAIN.

**C.** MODERATE - THIS IS WHEN YOUR PAIN WOULD CAUSE NOTICEABLE IMPAIRMENT IN THE PERFORMANCE OF THE ACTIVITY THAT INCREASES YOUR PAIN.

**D.** MARKED - THIS IS WHEN YOU ARE UNABLE PERFORM THE ACTIVITY OR ACTIVITIES DUE TO YOUR INCREASED LEVEL OF PAIN.

**FREQUENCY:**

**A.** INTERMITTENT - THIS IS WHEN THE PAIN IS LESS THAN 25% OF THE TIME.

**B.** OCCASIONAL - THIS IS WHEN THE PAIN OCCURS BETWEEN 25% TO 50% OF THE TIME.

**C.** FREQUENT - THIS IS WHEN THE PAIN OCCURS BETWEEN 50% TO 75% OF THE TIME.

**D.** CONSTANT - THIS IS WHEN THE PAIN OCCURS BETWEEN 75% AND 100% OF THE TIME.

4. WHAT AGGRAVATES THE PAIN?

WHAT RELIEVES IT?

WHEN DO YOU TYPICALLY FEEL THE PAIN?

IS IT BETTER OR WORSE IN THE MORNING OR EVENING?

**5.** HAVE YOU HAD THIS PROBLEM BEFORE? (YES / NO)
HOW WAS IT RESOLVED?________________________________________

DID YOU SEEK HELP OR TREATMENT? (YES /NO)

IS THE PAIN THE SAME? (YES / NO)

**6.** DO YOU HAVE RELATED SYMPTOMS; i.e. GRINDING, POPPING, GIVING WAY, NUMBNESS, TINGLING, WEAKNESS, DIZZINESS, OR NAUSEA? <u>CIRCLE ALL THAT APPLY</u>

**7.** HOW HAS **<u>THIS</u>** PROBLEM AFFECTED:

YOUR DRESSING, GROOMING, OR OTHER DAILY ACTIVITIES?

YOUR ABILITY TO WORK AT YOUR JOB OR AROUND THE HOUSE?

YOUR RECREATIONAL ACTIVITIES?

IS THERE ANYTHING THAT IS DIFFICULT OR IMPOSSIBLE FOR YOU TO DO SINCE THE ONSET OF THE PROBLEM?________________________________________

**8.** WHAT TREATMENT ARE YOU HAVING OR HAVE YOU HAD FOR **<u>THIS</u>** PROBLEM PRIOR TO TODAY? (FAMILY DOCTOR, ORTHOPEDIST, CHIROPRACTOR, OTHER)

OTHER:________________________________________________

NAME:________________________________________________

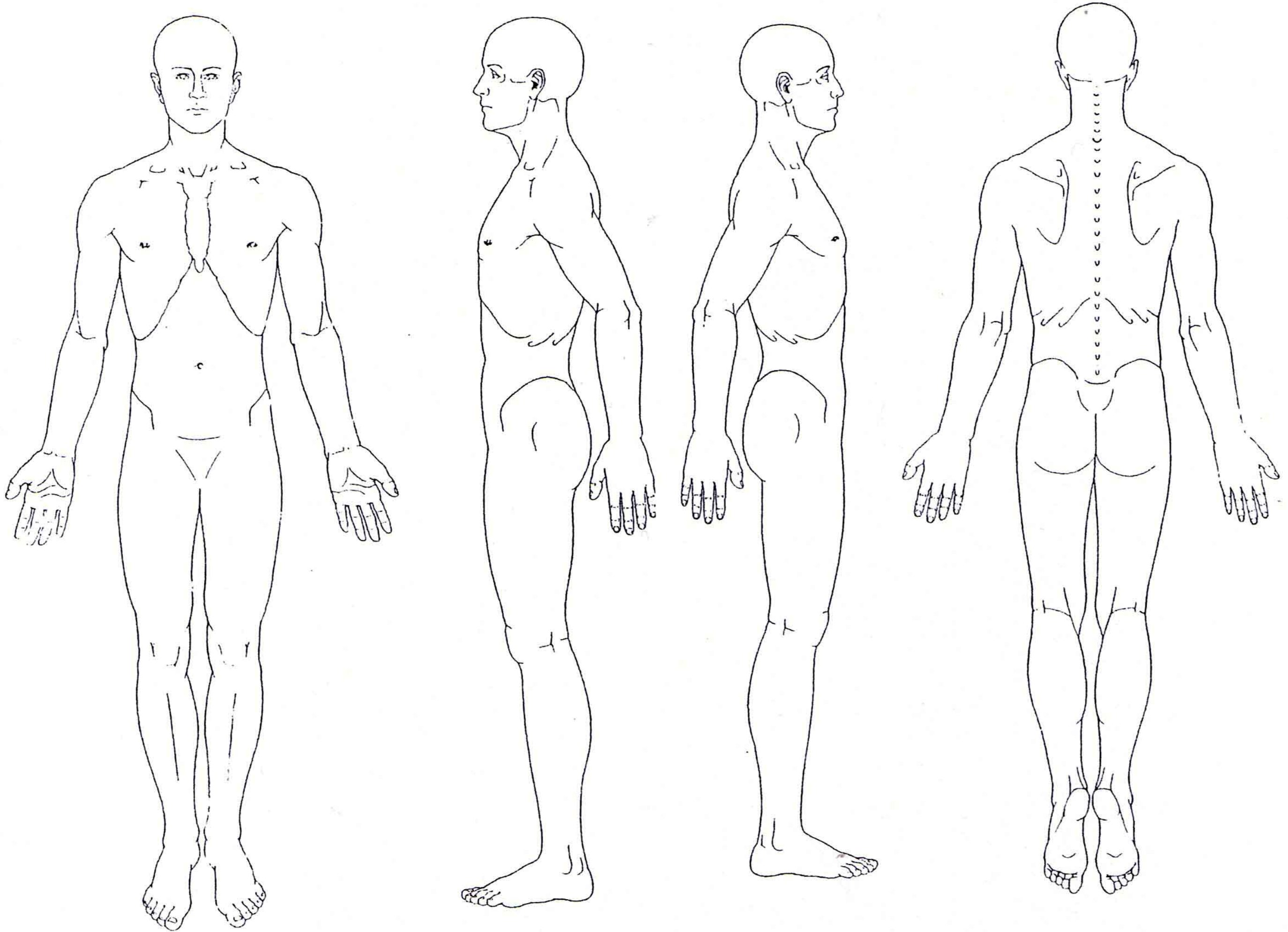
**9.** ARE YOU TAKING ANY MEDICATION FOR THIS PROBLEM OR FOR ANY OTHER REASON? (YES / NO) LIST MEDICATION(s)________________________________________
____________________________________________________

**10.** DO YOU BELIEVE THAT ANY OF THE TREATMENT THAT YOU HAVE RECEIVED HELPED YOUR CONDITION? (YES / NO) SPECIFIC TREATMENT:____________________________
____________________________________________________

**11.** HOW WOULD YOU RATE YOUR GENERAL HEALTH? (EXCELLENT, GOOD, FAIR, POOR)
LIST SPECIFIC PROBLEMS:________________________________________
____________________________________________________

**12.** WHAT IS YOUR OPINION OF WHAT THE PROBLEM IS?____________________________
____________________________________________________

## PAIN LOCATION



**Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.**

| | |
|---|---|
| **PPP** | **Where you experience Pain** |
| **NNN** | **Where you experience Numbness** |
| **TTT** | **Where you experience Tingling** |
| **BBB** | **Where you experience Burning** |
| **CCC** | **Where you experience Cramping** |

PATIENT SIGNATURE ______________________________ DATE ____________________

BELOW IS A LIST OF DAILY LIVING ACTIVITIES; IF ANY OF THE FOLLOWING ACTIVITIES ARE AFFECTED BY YOUR CONDITION, **PLEASE CIRCLE ALL THAT APPLY:**

**A.** SELF CARE AND PERSONAL HYGIENE:
URINATING, DEFECATING, BRUSHING TEETH, COMBING HAIR, BATHING, DRESSING ONESELF, OR EATING

**B.** COMMUNICATION:
WRITING, TYPING, SEEING, HEARING, OR SPEAKING

**C.** NORMAL LIVING POSTURES:
SITTING, LYING DOWN, OR STANDING

**D.** AMBULATION:
WALKING, CLIMBING STAIRS, OR RUNNING

**E.** TRAVEL:
DRIVING, RIDING, OR FLYING

**F.** NONSPECIALIZED HAND ACTIVITIES:
GRASPING, LIFTING, OR UNABLE TO FEEL OBJECTS

**G.** SOCIAL AND RECREATIONAL ACTIVITIES:
SPORTS, SEWING, COMPUTERS, ETC.

**H.** SLEEP:
UNABLE TO SLEEP DUE TO PAIN

OF THE ACTIVITIES THAT YOU CHOSE, WHICH ONES ARE AFFECTED: (BE SURE TO MATCH EACH LETTER MARKED ABOVE WITH A PERCENTAGE BELOW)

**INTERMITTENT** - 1% TO 25%______________________________
**OCCASIONAL** - 25% TO 50%______________________________
**FREQUENT**- 50% TO 75%______________________________
**CONSTANT** - 75% TO 100%______________________________

OF THE ACTIVITIES THAT YOU CIRCLED, PLEASE WRITE WHICH ONES ARE AFFECTED THE FOLLOWING WAYS: (BE SURE TO MATCH EACH LETTER MARKED ABOVE WITH AN OPTION BELOW)

**MINIMAL** - ______________________________________
(PAIN IS ANNOYING BUT CAUSES NO IMPAIRMENT IN THE PERFORMANCE OF ANY PARTICULAR ACTIVITY)

**SLIGHT** - ______________________________________________
(PAIN CAN BE TOLERATED BUT CAN CAUSE SOME DIFFICULTY IN THE PERFORMANCE OF THE ACTIVITY THAT INCREASES YOUR PAIN)

**MODERATE** - __________________________________________
(PAIN WOULD CAUSE NOTICEABLE IMPAIRMENT IN THE PERFORMANCE OF THE ACTIVITY THAT INCREASES YOUR PAIN)

**MARKED** - ____________________________________________
(YOU ARE UNABLE TO PERFORM THE ACTIVITY DUE TO YOUR INCREASED LEVEL OF PAIN)

**DOCTOR'S NOTES:**

Patient Account #:

## PERSONAL HISTORY

Date: ____________ Driver's License #: ____________ Social Security #: ____________

Name: ____________ (First / Middle / Last / (Sr. or Jr.)) Address: ____________

City: ____________ State: ____________ Zip: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

If no phone, name and phone # of friend who can reach you ____________

Name and phone # of person to contact in case of emergency: ____________

Birth date: ____________ Sex: ____________ Height: ____________ Weight: ____________

Employed By: ____________ Occupation: ____________

Circle if you are: *Married* *Single* *Widowed* *Divorced* *Separated*

Name of Spouse: ____________ Spouse's Social Security #: ____________

Spouse's Employer: ____________ Spouse's Work Phone: ____________

Ages of your children: ____________

Who is responsible for your bill: ☐ Self ☐ Husband or Wife Employer ☐ Insurance ☐ Other: ____________

Nearest relative not living with you: ____________ Phone: ( )

What health problem are you now having? ____________

When did this problem first occur? ____________

Is this visit the result of ☐ Accident or ☐ Injury Explain ____________

What other doctors have you seen for this condition? ____________

Have you had previous chiropractic care? ☐ Yes ☐ No If so, give name & location ____________

____________

If so, were x-rays taken? ☐ Yes ☐ No Results of Previous Care ____________

Are you taking any medication? (Please name) ____________

Referred to this office by: ____________

## PAST HEALTH HISTORY

**1. Operations:** Please Circle Applicable Items:

| | | | | |
|---|---|---|---|---|
| Appendix | Rectal | Tonsils | Gall Bladder | Female Organs |
| Hernia | Joints | Heart | Spine | Implants |
| Pacemaker | Other Surgical Procedures: ____________ | | | |

**2. Accidents or Falls:** (Please describe) ____________

____________

**3. Broken Bones or Dislocations:** ____________

**4. Diseases:** Circle any that you have had:

| | | | |
|---|---|---|---|
| Appendicitis | Malaria | Chicken Pox | Alcoholism |
| Scarlet Fever | Tuberculosis | Diabetes | Venereal Infection |
| Diphtheria | Whooping Cough | Cancer | Arthritis |
| Typhoid Fever | Anemia | Heart Disease | Epilepsy |
| Pneumonia | Measles | Goiter | Mental Disorder/Breakdown |
| Rheumatic Fever | Mumps | Influenza | Lumbago |
| Polio | Small Pox | Pleurisy | Eczema |

## 5. Symptoms:

Circle those you presently have,

Underline those you have had previously.

**GENERAL**
- Headache
- Fever
- Chills
- Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of sleep
- Fatigue
- Nervousness
- Depression
- Numbness or pain
- Allergies
- Wheezing
- Neuralgia
- Nausea

**EAR, NOSE, & THROAT**
- Failing vision
- Near sightedness
- Far sightedness
- Crossed eyes
- Blurred vision
- Deafness
- Earache
- Ear noises
- Ear discharge
- Sinus infection
- Nose bleeds
- Nasal obstruction
- Nasal drainage
- Sore throat
- Hoarseness
- Dental decay
- Gum disease
- Frequent colds
- Enlarged thyroid
- Tonsillitis
- Enlarged glands
- Hay fever

**SKIN**
- Skin eruptions
- Itching
- Bruise easily
- Dry skin
- Boils
- Moles
- Varicose veins
- Sensitive skin
- Hives or allergy

**RESPIRATORY**
- Chronic cough
- Spitting phlegm
- Spitting blood
- Chest pain
- Difficult breathing
- Shortness of breath

**CARDIOVASCULAR**
- Rapid heartbeat
- Slow heartbeat
- High blood pressure
- Low blood pressure
- Pain over heart
- Previous heart trouble
- Hardening of arteries
- Swelling of ankles
- Poor circulation
- Paralytic stroke

**MUSCLE & JOINT**
- Stiff neck
- Backache
- Swollen joints
- Painful joints
- Tremors
- Muscle or joint weakness
- Painful tail bone
- Foot trouble
- Pain between shoulders
- Spinal curvature
- Faulty posture

**GENITOURINARY**
- Frequent urination
- Painful urination
- Blood in urine
- Pus in urine
- Kidney infection or stones
- Bed wetting
- Inability to control urine
- Prostate trouble
- Hernia

**GASTROINTESTINAL**
- Poor appetite
- Poor digestion
- Excessive hunger
- Belching or gas
- Vomiting of blood
- Pain over stomach
- Distention of abdomen
- Constipation
- Diarrhea
- Colon trouble
- Hemorrhoids (Piles)
- Intestinal worms
- Liver trouble
- Gall bladder trouble
- Jaundice
- Colitis

**FOR WOMEN ONLY**
- Painful menstual periods
- Excessive flow
- Irregular cycle
- Cramps or backache
- Previous miscarriage
- Vaginal discharge
- Lumps in breast
- Menopausal symptoms
- Hot flashes
- Pregnant ☐ Yes ☐ No
- First day of your last Menstrual Cycle: ______________________

## 6. Other Information:

Please circle if you now have, or have had, any of the following:

| | | | |
|---|---|---|---|
| Diabetes | Stroke | Plastic or Metal Plates | Frequent Fractures |
| Seizures | Recent Surgeries | I.U.D. or Diaphragm | Multiple Fractures |
| Dizziness | Pacemaker | Spinal Tap or Injection | Spontaneous Fractures |
| High Blood Pressure | Implants | Osteoporosis | T.I.A. |
| AIDS or AIDS related complex | | Hepatitis B | Joint Replacement |

## 7. Habits: Indicate heavy, moderate, light, or none.

Coffee ________ Tea ________ Alcohol ________ Tobacco ________ Exercise ________

Sleep (# of hours) ________

What are your hobbies? ____________________________________________

## FAMILY HEALTH HISTORY

| Relation | Name | Age | Present Symptoms | Previous Serious Illness |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| | | | | |
| | | | | |
| Sisters | | | | |
| | | | | |
| | | | | |
| Children | | | | |
| | | | | |
| | | | | |

## INSURANCE COVERAGE

Nearly all insurance policies provide chiropractic coverage, but benefits vary from company to company and from policy to policy. Therefore, although we will fill out the insurance forms, the patient is personally responsible for payment of the bill. We do accept certain insurance assignments but all insurance arrangements must be approved in advance with the business office.

Check type of insurance coverage:

- ❑ Workman's Compensation
- ❑ Government Health Plan
- ❑ Personal Insurance
- ❑ Automobile Insurance
- ❑ Group Insurance
- ❑ Other
- ❑ HMO
- ❑ PPO

Name of Primary Insurance Company ______________________________

Employee I. D. # ____________________ Group # ______________

Name of Secondary Insurance Company ______________________________

Employee I. D. # ____________________ Group # ______________

To the best of my knowledge, the above information is true and accurate.

**Patient's Signature** ______________________________

**Signature of Parent or Guardian** ____________________ **S.S. #** ______________



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