



Peak Potential

CHIROPRACTIC & HOLISTIC HEALTH

Patient Information

Today's Date: _____

Date of Birth: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Contact Numbers (Please check preferred):

Mobile Phone: _____ Home Phone: _____ Work Phone : _____

Sex: M F

Marital status: S M D W

Occupation: _____

Employer: _____

Whom may we thank for referring you? _____

Previous chiropractor: _____

Primary care provider: _____

OB/Gyn – Midwife: _____

Authorization for Payment

I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits or for referral to any other healthcare provider. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Ramneek S. Bhogal, DC, DABCI or Stephanie O'Neill-Bhogal, DC, DICCP. By signing below I also acknowledge that I am responsible financially for this account.

Name: _____ Relationship to the patient: _____ Signature: _____ / /

Notice of Privacy Practices Acknowledgement

I have read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that I can receive a paper copy of the Notice of Privacy Practices upon request.

Name: _____ Relationship to the patient: _____ Signature: _____ / /

Health History Questionnaire:

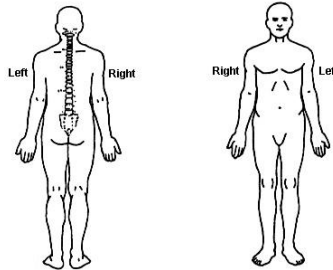
Patient Name: _____

Date: ___ / ___ / ___

Chief Complaint(s): _____

Have you seen another doctor for the complaint(s)? Yes No
Doctor's Name (if applicable) _____

Please mark the location of the complaint(s) on the drawings:



Past Medical History:

Have you ever had the following:

- | | | | |
|-------------------------------------|---------------------------------------|----------------------------------|--|
| <input type="radio"/> Measles | <input type="radio"/> Tuberculosis | <input type="radio"/> Cancer | <input type="radio"/> Whooping cough |
| <input type="radio"/> Mumps | <input type="radio"/> Glaucoma | <input type="radio"/> Polio | <input type="radio"/> Rheumatic fever |
| <input type="radio"/> Chicken pox | <input type="radio"/> Neck pain | <input type="radio"/> Hernia | <input type="radio"/> Venereal disease |
| <input type="radio"/> Scarlet fever | <input type="radio"/> Back pain | <input type="radio"/> Stroke | <input type="radio"/> Rheumatoid arthritis |
| <input type="radio"/> Diphtheria | <input type="radio"/> Hives/eczema | <input type="radio"/> Asthma | <input type="radio"/> Bladder infections |
| <input type="radio"/> Smallpox | <input type="radio"/> Infectious mono | <input type="radio"/> Ulcers | <input type="radio"/> High blood pressure |
| <input type="radio"/> Pneumonia | <input type="radio"/> Alcoholism | <input type="radio"/> Gout | <input type="radio"/> Low blood pressure |
| <input type="radio"/> Heart Disease | <input type="radio"/> Appendicitis | <input type="radio"/> Migraines | <input type="radio"/> Bleeding disorder |
| <input type="radio"/> Arthritis | <input type="radio"/> Kidney disease | <input type="radio"/> Anemia | <input type="radio"/> Diabetes-type 1 |
| <input type="radio"/> AIDS/HIV+ | <input type="radio"/> Thyroid disease | <input type="radio"/> Hepatitis | <input type="radio"/> Diabetes-type 2 |
| <input type="radio"/> Epilepsy | <input type="radio"/> Hemorrhoids | <input type="radio"/> Bronchitis | <input type="radio"/> other _____ |

Past surgeries (please give dates):

Injuries (please give dates):

Auto accidents _____ Falls _____

Dislocations _____ Broken Bones _____

List any medications that you take (prescription or over the counter):

Do you take nutritional supplements? Yes No

If so, which kind? _____

Do you have allergies? _____

Habits:

Use of tobacco: No Yes Packs per day ___ ___
 Use of alcohol: No Rarely Moderate Daily
 Use of caffeine: No Yes Cups per day (coffee or soda) ___ ___
 Exercise: None Moderate Daily

Family History (list any diseases) ex: Heart, Lung, Kidney, Cancer, etc.

Father _____
 Mother _____
 Siblings _____

Review of Systems - Please mark any personal history below:**Constitutional Symptoms**

- Good general health lately
- Recent weight change
- Fever
- Fatigue
- Headaches

Eyes

- Eye disease or injury
- Wear glasses/contacts
- Blurred or double vision

Ears/Nose/Throat

- Hearing loss or ringing
- Earaches or drainage
- Chronic sinus problem
- Nose bleeds
- Sore throat or voice change
- Swollen glands in neck

Cardiovascular

- Heart trouble
- Chest pain or angina
- Palpitation
- Shortness of breath
W/walking or lying flat

Respiratory

- Chronic or frequent cough
- Spitting up blood
- Shortness of breath
- Wheezing

Endocrine

- Glandular or hormone problem
- Excessive thirst or urination
- Heat or cold intolerance
- Skin becoming dryer
- Change in hat or glove size

Musculoskeletal

- Joint pain
- Joint stiffness or swelling
- Weakness of muscles or joints
- Muscle pain or cramps
- Back pain
- Cold extremities
- Difficulty in walking

Neurological

- Frequent or recurring headaches
- Light headed or dizzy
- Convulsions or seizures
- Numbness or tingling sensations
- Tremors
- Paralysis
- Head injury

Psychiatric

- Memory loss or confusion
- Nervousness
- Depression
- Insomnia

Gastrointestinal

- Loss of appetite
- Change in bowel movements
- Nausea or vomiting
- Frequent diarrhea
- Painful bowel movements
or constipation
- Rectal bleeding/blood in stool
- Abdominal pain

Hematologic/Lymphatic

- Slow to heal after cuts
- Bleeding or bruising tendency
- Anemia
- Phlebitis
- Past transfusion
- Enlarged glands

Genitourinary

- Frequent urination
- Burning/painful urination
- Blood in urine
- Incontinence or dribbling
- Kidney stones
- Sexual difficulty
- Male: testicle pain
- Female: pain with periods
- Female: irregular periods
- Female: vaginal discharge
- Female: # pregnancies ___
- Female: # miscarriages ___
- Female: date of last pap _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my doctor of any changes in my health status. I also authorize any necessary services I may need.

 Signature of Patient / Parent / Guardian

 Date