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:_________________ ___/___/___

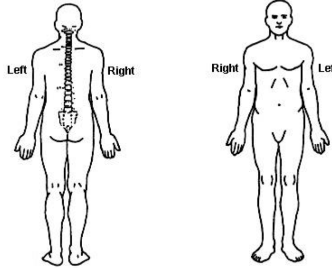
Health History Questionnaire:

Patient Name:_______________________ **Date:** ___ / ___ / ___

Chief Complaint(s): ____
____
____

Have you seen another doctor for the complaint(s)? O Yes O 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:

O Measles	O Tuberculosis	O Cancer	O Whooping cough
O Mumps	O Glaucoma	O Polio	O Rheumatic fever
O Chicken pox	O Neck pain	O Hernia	O Venereal disease
O Scarlet fever	O Back pain	O Stroke	O Rheumatoid arthritis
O Diphtheria	O Hives/eczema	O Asthma	O Bladder infections
O Smallpox	O Infectious mono	O Ulcers	O High blood pressure
O Pneumonia	O Alcoholism	O Gout	O Low blood pressure
O Heart Disease	O Appendicitis	O Migraines	O Bleeding disorder
O Arthritis	O Kidney disease	O Anemia	O Diabetes-type 1
O AIDS/HIV+	O Thyroid disease	O Hepatitis	O Diabetes-type 2
O Epilepsy	O Hemorrhoids	O Bronchitis	O 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? O Yes O No
If so, which kind? ____
Do you have allergies?____

Habits:

Use of tobacco:	O No	O Yes	Packs per day __ __	
Use of alcohol:	O No	O Rarely	O Moderate	O Daily
Use of caffeine:	O No	O Yes	Cups per day (coffee or soda) __ __	
Exercise:	O None	O Moderate	O 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
O Good general health lately
O Recent weight change
O Fever
O Fatigue
O Headaches

Eyes
O Eye disease or injury
O Wear glasses/contacts
O Blurred or double vision

Ears/Nose/Throat
O Hearing loss or ringing
O Earaches or drainage
O Chronic sinus problem
O Nose bleeds
O Sore throat or voice change
O Swollen glands in neck

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

Respiratory
O Chronic or frequent cough
O Spitting up blood
O Shortness of breath
O Wheezing

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

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

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

Psychiatric
O Memory loss or confusion
O Nervousness
O Depression
O Insomnia

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

Hematologic/Lymphatic
O Slow to heal after cuts
O Bleeding or bruising tendency
O Anemia
O Phlebitis
O Past transfusion
O Enlarged glands

Genitourinary
O Frequent urination
O Burning/painful urination
O Blood in urine
O Incontinence or dribbling
O Kidney stones
O Sexual difficulty
O Male: testicle pain
O Female: pain with periods
O Female: irregular periods
O Female: vaginal discharge
O Female: # pregnancies ___
O Female: # miscarriages ___
O 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

PREGNANCY HISTORY

Mother's Name ________________________________ Weeks gestation: __________ EDD: ___/___/___

Number of previous pregnancies: __________ Number of children: __________ LMP: ___/___/___

OB/Midwife: __________________________________

DURING YOUR PREGNANCY, HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO	
Falls?	☐	☐	________________
Motor vehicle accidents?	☐	☐	________________
Near-miss MVA?	☐	☐	________________
High blood pressure?	☐	☐	________________
Diabetes?	☐	☐	________________
Anemia?	☐	☐	________________
Morning sickness?	☐	☐	________________
Indigestion?	☐	☐	________________
Seizures?	☐	☐	________________
Swollen ankles?	☐	☐	________________
Thyroid problems?	☐	☐	________________
Heart problems?	☐	☐	________________
Back pain?	☐	☐	________________
Abnormal bleeding?	☐	☐	________________
Were you hospitalized?	☐	☐	________________
Any other illnesses?	☐	☐	________________

DURING YOUR PREGNANCY, HAVE YOU USED ANY OF THE FOLLOWING?

	YES	NO	
Tobacco?	☐	☐	________________
Alcohol?	☐	☐	________________
Non-prescribed drugs?	☐	☐	________________
Prescription medications?	☐	☐	Medication__________________ Reason __________________
Over-the-counter meds?	☐	☐	Medication__________________ Reason __________________

Completed by: ______________________________________ Today's Date: ____/____/____