

Patient Information:

## Active Body Chiropractic - Arnold

9428 SOUTH ELWOOD AVE SUITE 102, Jenks, OK 74037

Phone: 918-296-0525

Date			SSN	plan et		Birthday	The second second
First Name	-poling)	may (")	Middle Name	B-17 SHOTE	41	Last Name	
Sex -	O Male O Female	0 71	Height	- 100		Weight	972-101, and 765
Married/Civil Union:			Spouse Name	Non-we	THE CO	# of Children	Parent dall's may what
Home #	Cold	ngari 🗀	Cell#	The second second	d P	Work #	makes were being
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City	promocycle tiple	ntso 🗂	State	Eduja - up		Zip	
Emergency Contact	nds.	of n C	Emergency Relation	181 6		Emergency Phone	04-0000
Email	199	end [	1 1 30	On purpose the	a LU	1	GISTORIS
Complaint	Information:		1 / 1/2	A STATE OF THE STA	1 1-1		count depth of
Injury Occurred:	O Work O Aut	tomobile	O Third-Party (	Other	Injur	y Date:	married where it
Injury Origin:							-dependent of the
Desc Discomfort:	No. o	and H	4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	April	ant F7		and would be come
Interfere w/ Activities	s: O Yes O No	Affected	Sleep: O Yes O	No	Frequ	uency:	4.7
Missed Work:	O Yes O No	Unable	to Work from:		Unab	ole to Work Until:	and the State of t
Affected Appetite:	O Yes O No	Explain	Description of St.	all and a winter	7.03	- Constant of the con-	and the state of
Reduced Work:	O Yes O No	Explain	about the se		47	and the desirable	Shows to Life party
Does it Worsen:	O Yes O No	Explain	Carture	A STATE OF THE PARTY OF THE PAR			a manager
Weather Affects it:	O Yes O No	Explain	A September 1		at m	And the second second	Market and the second
Aggravates Condition	n:		Sangar di	The Publication and	N I	56 A 1 A 1	A CONTRACTOR OF THE PARTY OF TH
Improves Condition:	State of the		The second second	of the second			
Received Treatment:	O Yes O No	Explain		The second state of the			
X-rays Taken:	O Yes O No	Explain	r - amaliela riisi	the statement the st	mile a mi	de la competition della compet	e 2 solution any first does no
Pain level Rating - Sc	ale I to I0:	At its bes	At its Worst:	Current Level:			specialist day worked
Same Condition Befo	re: O Yes O No	Date:		anesis years recor	Pract	itioner:	(Agree entered)
Porconal H	ealth History					alorest C	Pint O torr
Last Physical Exam:	eaith History		Primary Phys:	eym	Ser la t	Phys Phone #:	property to be a few from
Phys City:		July 9	Phys State:		1:10	Phys Zip:	The same of the sa
Health Conditions:	a law course of the law of		,				
Previous Chiro Care:	O Yes O No	Date:		Condition(s) treate	ed:		
	O Yes O No	Planning	O Yes O No	_			
	0 165 0 100	rianning	, O res O No	11			
Medications:							



## **Health Checklist:**

Alcoholism	Allergies	Anemia			
Arteriosclerosis	Arthritis	Asthma			
Autoimmune Disease	Back Paig	☐ Bleeding Disorders			
Breast Lump	Bronchitis	Bruise Easily			
Cancer	Cataracts	Chest Pain			
☐ CHF	Cold Extremities	Constipation			
COPD/emphysema	Cramps	CVA (stroke/TIA)			
Dementia/Alzheimer's	Depression	Diabetes			
Diagnosed emotional/mental	Digestion Problems	Dizziness			
Epilepsy	Excessive Menstruation	Eye Pain or Difficulties			
Fatigue	Frequent Urination	Gallbladder disease/stones			
Glaucoma	Gout	Headache			
Hemorrhoids	High Blood Pressure	Hot Flashes			
Irregular Heart Beat	Irregular Menstrual Cycle	Kidney Infection			
☐ Kidney Stones	Liver disease/cirrhosis	Loss of Balance			
Loss of Memory	Loss of Smell	Loss of Taste			
Lung disease	Macular Degeneration	Migraines			
Nosebleeds	Pacemaker	Parkinson's			
Polio	Poor Posture	Prostate Trouble			
Retinal Disease	Sciatica .	Seizures			
Shortness of Breath	Sinus Infection	Skin Sensitivity			
Sleep Problems/Insomnia	Smoked	Spinal Curvatures			
Stroke	Swelling of Ankles	Swollen Joints			
☐ Thyroid Condition	Tuberculosis	Ulcers			
☐ Varicose Veins	☐ Venereal Disease	Other			
The second second second					
Have you had any of these Cardiovascular Diseases	Please select all that apply.				
Myocardial infarction	Hypertension	Hypercholesterolemia			
Bypass surgery	Coronary artery disease				
Do you have Diabetes? If so what type?					
O Type I O Type II O Juvenile					
Do you have any stomach/digestive issues? Please select all that apply.					
Ulcers	Reflux	☐ IBS			

Patient Symptoms:	amily Health History		7.7923
Ache / Dull  Sharp / Stabbing  Numb / Tingling			
Ache / Dull  Sharp / Stabbing  Numb / Tingling			
Ache / Dull  Sharp / Stabbing  Numb / Tingling	Patient Symptom		
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		Numb / Tingling	·{
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I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature	Date:
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