CTintake

# Active Body Chiropractic - Arnold

9428 SOUTH ELWOOD AVE SUITE 102, Jenks, OK 74037

Phone: 918-296-0525

## Patient Information:

| | | | | | |
|---|---|---|---|---|---|
| Date | | SSN | | Birthday | |
| First Name | | Middle Name | | Last Name | |
| Sex | ○ Male ○ Female | Height | | Weight | |
| Married/Civil Union: | | Spouse Name | | # of Children | |
| Home # | | Cell # | | Work # | |
| Address | | | | | |
| City | | State | | Zip | |
| Emergency Contact | | Emergency Relation | | Emergency Phone | |
| Email | | | | | |

## Complaint Information:

Injury Occurred: ○ Work ○ Automobile ○ Third-Party ○ Other Injury Date:

Injury Origin:

Desc Discomfort:

Interfere w/ Activities: ○ Yes ○ No Affected Sleep: ○ Yes ○ No Frequency:

Missed Work: ○ Yes ○ No Unable to Work from: Unable to Work Until:

Affected Appetite: ○ Yes ○ No Explain:

Reduced Work: ○ Yes ○ No Explain:

Does it Worsen: ○ Yes ○ No Explain:

Weather Affects it: ○ Yes ○ No Explain:

Aggravates Condition:

Improves Condition:

Received Treatment: ○ Yes ○ No Explain:

X-rays Taken: ○ Yes ○ No Explain:

Pain level Rating - Scale 1 to 10: At its best: ___ At its Worst: ___ Current Level: ___

Same Condition Before: ○ Yes ○ No Date: Practitioner:

## Personal Health History

Last Physical Exam: Primary Phys: Phys Phone #:

Phys City: Phys State: Phys Zip:

Health Conditions:

Previous Chiro Care: ○ Yes ○ No Date: Condition(s) treated:

Chance Pregnant: ○ Yes ○ No Planning: ○ Yes ○ No

Medications:

Supplements:

## Health Checklist:

- [ ] Alcoholism
- [ ] Allergies
- [ ] Anemia
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune Disease
- [ ] Back Pain
- [ ] 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

_____

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?

○ Type I ○ Type II ○ Juvenile

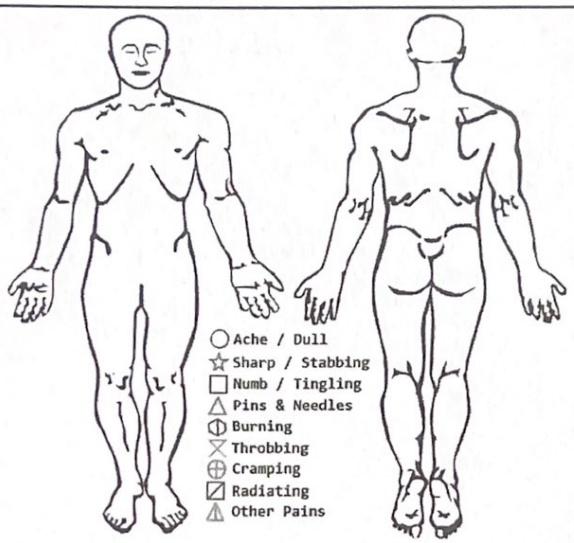
Do you have any stomach/digestive issues? Please select all that apply.

- [ ] Ulcers
- [ ] Reflux
- [ ] IBS

## Family Health History:

Family Health History

## Patient Symptoms:




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: _____