



# CONFIDENTIAL HEALTH INFORMATION

Osmon Chiropractic Center  
1332 Arch Haven Ave Ste. C  
Bloomington, IN 47403  
www.DrOsmon.com  
Phone: (812) 333-7447

Please allow our staff to photocopy your driver's license and insurance details.  
All information you supply is confidential. We comply with all federal privacy standards.  
Please print clearly.

Today's Date (MM/DD/YYYY)		Have you consulted a chiropractor before? <input type="radio"/> No <input type="radio"/> Yes		Patient Number (office use only)	
Whom may we thank for referring you?		When?		If so, whom?	
Age	Gender <input type="radio"/> Male <input type="radio"/> Female	Race <input type="radio"/> American Indian <input type="radio"/> Alaskan Native <input type="radio"/> Asian <input type="radio"/> Black or African American <input type="radio"/> Native Hawaiian <input type="radio"/> Other Pacific Islander <input type="radio"/> Other <input type="radio"/> White <input type="radio"/> Decline to answer		Ethnicity <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Decline to specify	
Birth Date (MM/DD/YYYY)		Your Last Name		Your Social Security Number	
Your First Name		Your Middle Name (or Initial)		Smoking Status (age 13 and over) <input type="radio"/> Never A Smoker <input type="radio"/> Former Smoker <input type="radio"/> Current Every Day Smoker <input type="radio"/> Current Some Day Smoker <input type="radio"/> Heavy Smoker <input type="radio"/> Light Smoker	
Address		Marital Status <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Separated		Preferred Language	
City	State/Province	ZIP/Postal Code		Spouse's Name	
Home Phone		Cell Phone		Child's Name and Age	
Email Address		Emergency Contact		Emergency Contact's Phone	
Your Occupation		Your Employer		Child's Name and Age	
Address		City		State/Province	
Primary Care Provider's Name		Primary Care Provider's Phone		ZIP/Postal Code	
Insurance Carrier		Policy Number		May we contact you at work? <input type="radio"/> Yes <input type="radio"/> No	
Insured's Last Name		Insured's First Name		Preferred method of contact? <input type="radio"/> Home Phone <input type="radio"/> Cell Phone <input type="radio"/> Work Phone <input type="radio"/> Email	
Insured's Middle Name (or Initial)		Insured's Employer		Who carries this policy? <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Parent	
Address		City		State/Province	
ZIP/Postal Code		Employer's Phone			

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

**Primary Complaint**

The primary symptom that prompted me to seek care today is: \_\_\_\_\_

**And are the result of (darken circle):**

- An accident or injury  
 Work  Auto  Other \_\_\_\_\_

- A worsening long-term problem  
 An interest in:  Wellness  Other \_\_\_\_\_

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture  
 Over-the-counter drugs  Chiropractic  
 Homeopathic remedies  Massage  
 Physical therapy  Ice  
 Surgery  Heat  
 Other \_\_\_\_\_

**Secondary Complaint**

The secondary symptom that prompted me to seek care today is: \_\_\_\_\_

**And are the result of (darken circle):**

- An accident or injury  
 Work  Auto  Other \_\_\_\_\_

- A worsening long-term problem  
 An interest in:  Wellness  Other \_\_\_\_\_

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture  
 Over-the-counter drugs  Chiropractic  
 Homeopathic remedies  Massage  
 Physical therapy  Ice  
 Surgery  Heat  
 Other \_\_\_\_\_

**Additional Complaint**

The additional symptom that prompted me to seek care today is: \_\_\_\_\_

**And are the result of (darken circle):**

- An accident or injury  
 Work  Auto  Other \_\_\_\_\_

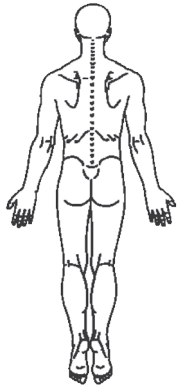
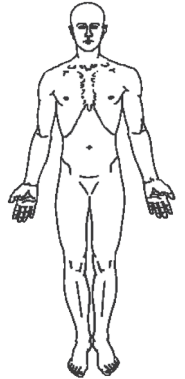
- A worsening long-term problem  
 An interest in:  Wellness  Other \_\_\_\_\_

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture  
 Over-the-counter drugs  Chiropractic  
 Homeopathic remedies  Massage  
 Physical therapy  Ice  
 Surgery  Heat  
 Other \_\_\_\_\_

**Location**  
 (Where does it hurt?)  
 Circle the area(s) on the illustration.  
 "O" for current condition  
 "X" for conditions experienced in the past



1. What else should Osmon Chiropractic Center know about your current condition? \_\_\_\_\_

2. How does your current condition interfere with your:

Work or career: \_\_\_\_\_

Recreational activities: \_\_\_\_\_

Household responsibilities: \_\_\_\_\_

Personal relationships: \_\_\_\_\_

3. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Osteoporosis                   | <input type="radio"/> Arthritis                      | <input type="radio"/> Scoliosis                      | <input type="radio"/> Neck pain                      | <input type="radio"/> Back problems                  | <input type="radio"/> Hip disorders                  | Initials _____             |
| <input type="radio"/> Knee injuries                  | <input type="radio"/> Foot/ankle pain                | <input type="radio"/> Shoulder problems              | <input type="radio"/> Elbow/wrist pain               | <input type="radio"/> TMJ issues                     | <input type="radio"/> Poor posture                   |                            |

b. Neurological

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anxiety                        | <input type="radio"/> Depression                     | <input type="radio"/> Headache                       | <input type="radio"/> Dizziness                      | <input type="radio"/> Pins and needles               | <input type="radio"/> Numbness                       | Initials _____             |

c. Cardiovascular

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> High blood pressure            | <input type="radio"/> Low blood pressure             | <input type="radio"/> High cholesterol               | <input type="radio"/> Poor circulation               | <input type="radio"/> Angina                         | <input type="radio"/> Excessive bruising             | Initials _____             |

d. Respiratory

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Asthma                         | <input type="radio"/> Apnea                          | <input type="radio"/> Emphysema                      | <input type="radio"/> Hay fever                      | <input type="radio"/> Shortness of breath            | <input type="radio"/> Pneumonia                      | Initials _____             |

e. Digestive

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anorexia/bulimia               | <input type="radio"/> Ulcer                          | <input type="radio"/> Food sensitivities             | <input type="radio"/> Heartburn                      | <input type="radio"/> Constipation                   | <input type="radio"/> Diarrhea                       | Initials _____             |

f. Sensory

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Blurred vision                 | <input type="radio"/> Ringing in ears                | <input type="radio"/> Hearing loss                   | <input type="radio"/> Chronic ear infection          | <input type="radio"/> Loss of smell                  | <input type="radio"/> Loss of taste                  | Initials _____             |

g. Skin

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Skin cancer                    | <input type="radio"/> Psoriasis                      | <input type="radio"/> Eczema                         | <input type="radio"/> Acne                           | <input type="radio"/> Hair loss                      | <input type="radio"/> Rash                           | Initials _____             |

\_\_\_\_\_  
**Patient name**

\_\_\_\_\_  
**Patient Number**  
 (office use only)

\_\_\_\_\_  
**Doctor's Initials**

**Osmon Chiropractic Center**

(Continued from previous page)

**h. Endocrine**

- Had  Have  Thyroid issues    Had  Have  Immune disorders    Had  Have  Hypoglycemia    Had  Have  Frequent infection    Had  Have  Swollen glands    Had  Have  Low energy    NONE

Initials \_\_\_\_\_

**i. Genitourinary**

- Had  Have  Kidney stones    Had  Have  Infertility    Had  Have  Bedwetting    Had  Have  Prostate issues    Had  Have  Erectile dysfunction    Had  Have  PMS symptoms    NONE

Initials \_\_\_\_\_

**j. Constitutional**

- Had  Have  Fainting    Had  Have  Low libido    Had  Have  Poor appetite    Had  Have  Fatigue    Had  Have  Sudden weight gain/loss (circle one)    Had  Have  Weakness    NONE

Initials \_\_\_\_\_

Patient name \_\_\_\_\_

Patient Number (office use only) \_\_\_\_\_

All other systems negative

**Past Personal, Family and Social History**

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

<b>PERSONAL</b>	<b>4. Illnesses</b> Check the illnesses you have <b>Had</b> in the past or <b>Have</b> now.		<b>5. Operations</b> Surgical interventions, which may or may not have included hospitalization.		<b>6. Treatments</b> Check the ones you've received in the <b>Past</b> or are receiving <b>Currently</b> .	
	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Past <input type="radio"/> Currently <input type="radio"/>		
	<input type="radio"/> <input type="radio"/> AIDS	<input type="radio"/> <input type="radio"/> Tuberculosis	<input type="radio"/> <input type="radio"/> Appendix removal	<input type="radio"/> <input type="radio"/> Acupuncture		
	<input type="radio"/> <input type="radio"/> Alcoholism	<input type="radio"/> <input type="radio"/> Typhoid fever	<input type="radio"/> <input type="radio"/> Bypass surgery	<input type="radio"/> <input type="radio"/> Antibiotics		
	<input type="radio"/> <input type="radio"/> Allergies	<input type="radio"/> <input type="radio"/> Ulcer	<input type="radio"/> <input type="radio"/> Cancer	<input type="radio"/> <input type="radio"/> Birth control pills		
	<input type="radio"/> <input type="radio"/> Arteriosclerosis	<input type="radio"/> <input type="radio"/> Other: _____	<input type="radio"/> <input type="radio"/> Cosmetic surgery	<input type="radio"/> <input type="radio"/> Blood transfusions		
	<input type="radio"/> <input type="radio"/> Cancer		<input type="radio"/> <input type="radio"/> Elective surgery: _____	<input type="radio"/> <input type="radio"/> Chemotherapy		
	<input type="radio"/> <input type="radio"/> Chicken pox		<input type="radio"/> <input type="radio"/> Eye surgery	<input type="radio"/> <input type="radio"/> Chiropractic care		
	<input type="radio"/> <input type="radio"/> Diabetes	<b>7. Allergies</b> Are you allergic to any medications?	<input type="radio"/> <input type="radio"/> Hysterectomy	<input type="radio"/> <input type="radio"/> Dialysis		
	<input type="radio"/> <input type="radio"/> Epilepsy	Yes <input type="radio"/> No <input type="radio"/>	<input type="radio"/> <input type="radio"/> Pacemaker	<input type="radio"/> <input type="radio"/> Herbs		
	<input type="radio"/> <input type="radio"/> Glaucoma	<input type="radio"/> <input type="radio"/> If Yes please list: _____	<input type="radio"/> <input type="radio"/> Spine _____	<input type="radio"/> <input type="radio"/> Homeopathy		
	<input type="radio"/> <input type="radio"/> Goiter		<input type="radio"/> <input type="radio"/> Tonsillectomy	<input type="radio"/> <input type="radio"/> Hormone replacement		
	<input type="radio"/> <input type="radio"/> Gout		<input type="radio"/> <input type="radio"/> Vasectomy	<input type="radio"/> <input type="radio"/> Inhaler		
	<input type="radio"/> <input type="radio"/> Heart disease		<input type="radio"/> <input type="radio"/> Other: _____	<input type="radio"/> <input type="radio"/> Massage therapy		
	<input type="radio"/> <input type="radio"/> Hepatitis			<input type="radio"/> <input type="radio"/> Physical therapy		
	<input type="radio"/> <input type="radio"/> HIV Positive			<input type="radio"/> <input type="radio"/> Medications		
	<input type="radio"/> <input type="radio"/> Malaria			<small>(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals):</small>		
	<input type="radio"/> <input type="radio"/> Measles			_____		
	<input type="radio"/> <input type="radio"/> Multiple Sclerosis			_____		
	<input type="radio"/> <input type="radio"/> Mumps			_____		
	<input type="radio"/> <input type="radio"/> Polio	<b>8. Injuries</b> Have you ever...	<input type="radio"/> <input type="radio"/> Had a fractured or broken bone	<input type="radio"/> <input type="radio"/> Used a crutch or other support		
	<input type="radio"/> <input type="radio"/> Rheumatic fever		<input type="radio"/> <input type="radio"/> Had a spine or nerve disorder	<input type="radio"/> <input type="radio"/> Used neck or back bracing		
	<input type="radio"/> <input type="radio"/> Scarlet fever		<input type="radio"/> <input type="radio"/> Been knocked unconscious	<input type="radio"/> <input type="radio"/> Received a tattoo		
	<input type="radio"/> <input type="radio"/> Sexually transmitted disease		<input type="radio"/> <input type="radio"/> Been injured in an accident	<input type="radio"/> <input type="radio"/> Had a body piercing		
	<input type="radio"/> <input type="radio"/> Stroke					

Consultation Notes

**9. Family History**

Some health issues are hereditary. Tell Osmon Chiropractic Center about the health of your immediate family members.

	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
<b>FAMILY</b>	Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

**10. Are there any other hereditary health issues that you know about?** \_\_\_\_\_

**11. Social History**

Tell Osmon Chiropractic Center about your health habits and stress levels.

<b>SOCIAL</b>	Alcohol use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes <input type="radio"/> No
	Coffee use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes <input type="radio"/> No
	Tobacco use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes <input type="radio"/> No
	Exercising	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes <input type="radio"/> No
	Pain relievers	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes <input type="radio"/> No
	Soft drinks	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No
	Water intake	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____		
	Hobbies:	_____			

Doctor's Initials \_\_\_\_\_

Osmon Chiropractic Center

**12. Activities of Daily Living**

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name \_\_\_\_\_

Patient Number  
(office use only)

13. What is the major stressor in your life? \_\_\_\_\_ 14. How much sleep do you average per night? \_\_\_\_\_ Hours

15. What is the type and approximate age of your mattress and pillow? \_\_\_\_\_ 16. What is your preferred sleeping position? \_\_\_\_\_

17. Describe your typical eating habits:  Skip breakfast  Two meals a day  Three meals a day  Snacking between meals

18. What would be the most significant thing that you could do to improve your health? \_\_\_\_\_

19. In addition to the main reason for your visit today, what additional health goals do you have? \_\_\_\_\_

**Acknowledgements**

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials \_\_\_\_\_ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials \_\_\_\_\_ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials \_\_\_\_\_ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): \_\_\_\_\_**

Initials \_\_\_\_\_ **I grant permission to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials \_\_\_\_\_ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials \_\_\_\_\_ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Consultation Notes

Doctor's Initials \_\_\_\_\_

Osmon Chiropractic Center

\_\_\_\_\_  
Patient (or Guardian's) signature

\_\_\_\_\_  
Date (MM/DD/YYYY)