Southern Oregon Chiropractic

2931 Doctors Park Drive Medford, OR 97504
977 Royal Avenue Medford, OR 97504
410 N Main Street Ashland, OR 97520
Phone (541) 245-4444 Fax (541) 245-4443

CONDITIONS OF SERVICES RENDERED

FINANCIAL AGREEMENT: I agree, whether I sign as agent or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account with Southern Oregon Chiropractic in accordance with the regular rates and terms. Late fees may occur when payments are not made on time. Should
the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's
fees, and collection expenses. In addition, professional courtesies may be removed.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize, whether I sign as agent or as patient, direct payment to Southern Oregon Chiropractic of any insurance benefits otherwise payable to or on behalf of the patient for the visit or for these outpatient services at a rate not to exceed Southern Oregon Chiropractic's actual charges. I understand that I am financially responsible for charges, deductibles, and co-insurance not covered by insurance.

HEALTH PLAN OBLIGATIONS: Southern Oregon Chiropractic maintains a list of health plans with which it contracts. Southern Oregon Chiropractic has no contract, expressed or implied, with any plan that does not appear on that list. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to him/her by Southern Oregon Chiropractic if he/she belongs to a plan, which does not appear on the above- mentioned list.

RELEASE OF INFORMATION: I authorize Southern Oregon Chiropractic to release any information necessary to provide medical treatment to me, allow Southern Oregon Chiropractic to bill and be paid for services they provide. I understand that releasing information for any reason other than those listed above requires a separate authorization by me. I also understand that I have the right to request restrictions on the use of my health information, but Southern Oregon Chiropractic is not obligated to honor that request unless required to do so by State or Federal regulations. This consent shall be effective as long as necessary to obtain payment.

INSURANCE BENEFIT VERIFICATIONS: Southern Oregon Chiropractic will verify your insurance benefits as a courtesy. Verifications do not guarantee payment from your insurance company.

The Terms and conditions of this agreement are not binding until the patient receives care and treatment from Southern Oregon Chiropractic. The undersigned certifies that he/she had read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

DATE: _____ PRINT NAME:_____

SIGNATURE:_____
(PATIENT/PARENT/CONSERVATOR/GUARDIAN)

If signed by other than patient, indicate relationship: _____

****** ATTENTION PATIENTS ******
Scheduled appointments that are not cancelled 24 hours in advance will incur an annoyance fee of: $25.00

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PATIENT ACKNOWLEDGEMENT FORM

Receipt of Joint Notice of Privacy Practices

By my signature below, I hereby acknowledge that I have received a copy of Southern Oregon Chiropractic's *Notice of Privacy Practices*. Southern Oregon Chiropractic is permitted to use or disclose my health information to carry out treatment, payment or health care operations. Health information means any and all information relating to health care services provided to me, including information related to services provided to me prior to the date I sign the acknowledgement form.

I understand the Southern Oregon Chiropractic's Notice of Privacy Practices explains the types of uses or disclosures that Southern Oregon Chiropractic may make and my rights with respect to my health information. I understand that if I have any questions or concerns about this Notice, I may contact the Office Manager at the telephone number listed below. I further understand Southern Oregon Chiropractic may change the terms of the Notice of Privacy Practices from time to time, and that I may contact the Office Manager to obtain a revised version of the notice at any time.

Patient's Printed Name:_____Patient's DOB: _____

Signature of patient:_____Date: _____

Signature other than patient: _____ Date: _____

If signed by other than patient, indicate relationship:_____

You may contact our office regarding your privacy by calling 541-245-4444

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Please Print

Patient Registration Form

Patient name_____Male___ Female ___ Date of birth _____/_____/_____

Mailing address_____City _____State _____ Zip_____

Home Phone _____ Cell Phone _____ SSN# _____-_____-_____

Email:_____Single _____ Married _____ Divorced _____ Widowed _____

Employer_____Phone

Is it okay to leave medical information on your voicemail if we are unable to reach you? Yes_____ No _____

Emergency Contact

Name _____ Relationship _____ Phone_____

Spouse's name_____Date of birth_____

Spouse's SSN# _____-_____-_____ Phone _____

Spouse's Employer_____Phone _____

Medical Insurance Information

Primary Insurance _____

ID Number _____ Group Number _____

Insured name _____ Date of birth _____

Secondary Insurance _____

ID Number _____Group Number_____

Insured name _____Date of birth_____

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Implied Consent

Dear Patient:
It is prudent for us to obtain your informed consent prior to examination and treatment. The purpose of this information is to inform you, not to alarm you. What you are being asked to sign is simply a confirmation that we have discussed the following:

Associates and Assistants
In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, and treatment. Occasionally when your doctor is unavailable, another clinic doctor will treat you.

Examinations
X-ray: Concerning x-ray examination, this office uses highly sensitive screens and a state of the art high frequency machine that provides the highest quality diagnostic films with the least amount of exposure. The actual dose of energy needed for films is approximately 40% less than older machines. This is important since certain conditions will call for the retaking of certain x-rays when circumstances warrant.

The only noteworthy inherent risk with taking x-rays, deals with pregnancy. If there is a possibility that you are pregnant, inform this office prior to x-ray examination. If there is no possibility of this condition, the inherent risks are so rare that I have no available statistics to quantify their probability.

Treatment
The Chiropractic Adjustment: I will use my hands upon your body in such a way as to move your joints. This procedure may cause an audible “pop” or “click” much as you have experienced when you “crack” your knuckles. There are some material risks involved in doing this and they are as follows:

Inherent Risks
Pain: It is common for an adjustment as well as traction, massage therapy, exercise, in fact, almost any treatment, to result in temporary increase in soreness in the region being treated.

Soft Tissue Injury: Soft tissue, such as ligaments and muscle may be stretched or torn during an adjustment. The result is a temporary increase in pain. However, there are no long term affects. These problems occur so rarely I have not been able to find available statistics to quantify their probability.

Rib Fractures: The force of an adjustment might “crack” a rib. This can happen with anyone, however, it occurs most often in patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays and when detected, we proceed with extra caution. These problems occur so rarely that I have not been able to find available statistics to quantify their probability.

Disc Herniation: Occasionally treatment will aggravate or cause a problem if the disc is in a weakened state. It is possible that surgery may become necessary for correction, but again these problems occur so rarely that I have not been able to find available statistics to quantify their probability.

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Stroke: Even though strokes happen with some frequency in our world, strokes resulting from chiropractic adjustments are rare. So rare that you have the same chance of getting hit by lightning; one in a million.

Physical Therapy Burns: The electric heating pad that we use generates heat. We will also use ice in the office. Since everyone's skin has different sensitivity to these modalities, we test our patients for sensitivity deficiencies prior to therapy use. If a burn is obtained, there will be a temporary pain and possible blistering. This should be reported to a doctor. This is so rare that I have not been able to find available statistics to quantify their probability. The chances of this happening with our heating pads is reduced even further since you, the patient, will be able to turn the pad off if it ever becomes too warm.

Other Problems: There may be other problems or complications that might arise from treatment, such as massage, traction, etc., then noted above. These other problems or complications occur so rarely that it is not plausible to anticipate and/or explain them all in advance of treatment.

Other Treatment Options (non-chiropractic):
Medication: Medication may be used to relieve pain and swelling. However, medication can mask progress and the efficiency of chiropractic treatment. Caution should be used since the danger of side effects and damage to the health of the person taking the medication is well documented.

Hospitalization: Hospitalization has proven expensive and dangerous. The documentation of such is overwhelming.

Surgery: Surgery is always a possibility. The expense, danger and ineffectiveness of such treatment is more a probability than a possibility.

Non Treatment
Remaining untreated, results in adhesions, pain, and reduction in associated joint mobility. The probability that these adhesions will interfere with the motion, function and enjoyment of life is very high.

THE DOCTOR HAS EXPLAINED TO ME THE MOST LIKELY COMPLICATIONS OF THE POSSIBLE UNDESIRED RESULTS OF HIS EXAMINATION AND TREATMENT, AND I UNDERSTAND THEM.

I hereby authorize and direct the physician with associates or assistants to provide such additional services as they may deem reasonable and necessary.

Consent to Treatment

I HEREBY STATE THAT I HAVE READ OR HAVE HAD READ TO ME THIS CONSENT FORM PRIOR TO MY SIGNATURE.

Patient's Signature: _____ Date: _____

Printed Name: _____

Signature of Parent/Guardian: _____

Chief Complaint – HPI (History of Present Illness)

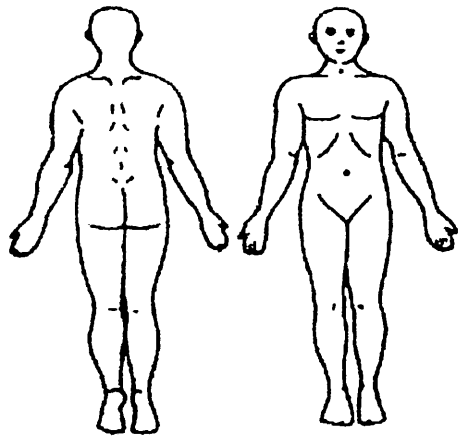
Patient Name: _____ Date: _____ **Dr:** _____

Chief Complaint: _____

PLEASE LABEL THE DIAGRAM

Body Area(s) Involved: ☐ Cervical ☐ Spine, Ribs, Pelvis ☐ Upper Extremity ☐ Lower Extremity

Key: A=Ache B=Burning N = Numbness



Condition: ☐ New → ☐ Acute or ☐ Chronic
☐ Recurrence (Acute) ☐ Exacerbation (Acute) ☐ Chronic

Mechanism of Onset:
☐ Auto: ☐ Driver/Passenger ☐ Pedestrian
☐ Work Related: ☐ Fall ☐ Falling Object ☐ Lifting
☐ Overexertion ☐ Repetitive Motion ☐ Other: _____
☐ Other – Liability: ☐ Slip or Fall ☐ Other: _____
☐ Other – No Liability: ☐ Etiology Unknown ☐ Overexertion ☐ Repetitive Use
☐ Slept Wrong ☐ Slip or Fall ☐ No Injury

Description of Onset of Complaint: _____

Current Symptoms: ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Location: Left / Right / Bilateral _____

Quality: ☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Radiating ☐ Sharp ☐ Shooting
☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Other _____

Level of Impairment Due to Symptoms (Resting):

0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9 10

Duration: Started: _____
Last Occurred: _____ Last episode: _____ Resolved Previous Visit: _____
Worsened: _____ Injury Occurred: _____ Accident Occurred: _____

Timing: *Worse*: ☐ Morning ☐ Afternoon ☐ Night ☐ with Activity; ☐ Constant ☐ Intermittent

Context: *Better with:* ☐ Warm Temp ☐ Cold Temp *Worse with:* ☐ Warm Temp ☐ Cold Temp ☐ Damp

Assoc Signs and Symptoms: ☐ Blurred Vision ☐ Depression ☐ Dizziness ☐ Irritability/Mood Swing
☐ Localized Tingling ☐ Nausea ☐ Ringing in Ears ☐ Sleep Disturbance ☐ Stiffness

Headaches: Location: ☐ Occipital ☐ Frontal ☐ Left Temporal ☐ Right Temporal ☐ Parietal ☐ Sinus
Quality: ☐ Dull ☐ Sharp ☐ Throbbing ☐ Stabbing ☐ Aura ☐ No Aura
Types: ☐ Hat Band ☐ Cluster ☐ Migraine ☐ Tension

Other: (frequency/duration/time of day) _____

Radiation: Left / Right / Bilateral _____

Weakness: Left / Right / Bilateral _____

Other Assoc Signs and Symptoms:

☐ aches	☐ burning	☐ cold limb(s)	☐ difficulty walking	☐ dizziness
☐ ecchymosis	☐ chronic fatigue	☐ fever	☐ heartburn	☐ joint stiffness
☐ muscle spasm	☐ muscle weakness	☐ nausea	☐ numbness	☐ pale bluish skin
☐ panic	☐ pins & needles	☐ rhinorrhea (runny nose)	☐ shortness of breath	☐ sweating
☐ swelling	☐ tingling	☐ vomiting		

Modifying Factors:

Symptoms Better With: ☐ nothing helps ☐ activity ☐ bending ☐ applying cold ☐ applying heat
☐ massage ☐ movement ☐ OTC meds ☐ Rx meds ☐ rest
☐ stretching ☐ sitting ☐ standing ☐ twisting ☐ walking

Symptoms Worse With: (as noted in Social History)

Daily Activities: Effects of Current Condition on Performance

Bending:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Care –Infirm Family:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Carrying Groceries:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Change Posn–Sit-Stand:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Climb Stairs:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Driving:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Extended Computer Use:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Feeding:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Household Chores:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Kneeling:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Lift Children:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Lifting:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Pet Care:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Reading (Concentration):	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Self Care:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Self Care–Bathing:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Self Care–Dressing:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Self Care–Shaving:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Sexual Activities:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Sleep:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Static Sitting:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Static Standing:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Walking:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Yard Work:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform

Employment:

Occupation/Job Title: _____ **Work:** _____ **hrs / day or week**
Description of Work: _____
Job Classification: ☐ **Sedentary** (<5lbs) ☐ **Light** (5-20lbs) ☐ **Moderate** (20-50lbs) ☐ **Heavy** (>50 lbs)
Lifting Frequency: ☐ **Constant** (67-100%/day) ☐ **Frequent** (33-66%/day) ☐ **Occasional** (0-32%/day)
Lifting Postures: ☐ **with Arms** ☐ **High Near** ☐ **from Knee** ☐ **Off Posture** ☐ **from Torso**
Work Activity Postures: (hrs/day)
☐ **bending:** _____**h/d** ☐ **climbing:** _____**h/d** ☐ **kneeling:** _____**h/d** ☐ **pulling:** _____**h/d** ☐ **pushing:** _____**h/d**
☐ **reaching:** _____**h/d** ☐ **sitting:** _____**h/d** ☐ **standing:** _____**h/d** ☐ **twisting:** _____**h/d** ☐ **walking:** _____**h/d**

Repetitive Activities: (hrs/day)
☐ **assembly/fine manipulation:** _____**h/d** ☐ **computer use/typing:** _____ **h/d** ☐ **grasping:** _____ **h/d**
☐ **hand tool use:** _____ **h/d** ☐ **operation of machinery controls:** _____ **h/d** ☐ **phone use:** _____**h/d**

Condition's Effect On Job Performance:

Mild Painful (Can do) **Mod** Painful (limited ability) **Mod/Sev** Limited Duty **Sev** No Limited Duty ☐ **Sev** (can't do limited duty)

Recreational Activity: Effects of Current Condition on Performance

_____	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
_____	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform

Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ chills ☐ fatigue ☐ night sweats ☐ weight loss
☐ daytime drowsiness ☐ fever ☐ weight gain

Eyes/Vision: ☐ I DENY having any of the symptoms or problems listed below.

☐ blindness ☐ change in vision ☐ field cuts ☐ photophobia
☐ blurred vision ☐ double vision ☐ glaucoma ☐ tearing
☐ cataracts ☐ eye pain ☐ itching ☐ wear glasses/contacts

Ears, Nose and Throat: ☐ I DENY having any of the symptoms or problems listed below.

☐ bleeding ☐ ear drainage ☐ hearing loss ☐ nosebleeds ☐ sore throat
☐ dentures ☐ ear pain ☐ history of head injury ☐ postnasal drip ☐ tinnitus(ringing in ears)
☐ difficulty swallowing ☐ fainting ☐ hoarseness ☐ rhinorrhea (runny nose) ☐ TMJ problems
☐ discharge ☐ frequent sore throats ☐ loss of sense of smell ☐ sinus infections
☐ dizziness ☐ headaches ☐ nasal congestion ☐ snoring

Respiration: ☐ I DENY having any of the symptoms or problems listed below.

☐ asthma ☐ coughing up blood ☐ sputum production
☐ cough ☐ shortness of breath ☐ wheezing

Cardiovascular: ☐ I DENY having any of the symptoms or problems listed below.

☐ angina (chest pain or discomfort) ☐ high blood pressure ☐ shortness of breath with exertion or exercise
☐ chest pain ☐ low blood pressure ☐ swelling of legs
☐ claudication (leg pain/ache) ☐ orthopnea (difficulty breathing lying down) ☐ ulcers
☐ heart murmur ☐ palpitations ☐ varicose veins
☐ heart problems ☐ paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)

Gastrointestinal: ☐ I DENY having any of the symptoms or problems listed below.

☐ abdominal pain ☐ diarrhea ☐ indigestion ☐ abnormal stool caliber ☐ vomiting blood
☐ belching ☐ difficulty swallowing ☐ jaundice ☐ abnormal stool color
☐ black - tarry stools ☐ heartburn ☐ nausea ☐ abnormal stool consistency
☐ constipation ☐ hemorrhoids ☐ rectal bleeding ☐ vomiting

Female: ☐ I DENY having any of the symptoms/problems and/or using any of the items listed below.

☐ birth control ☐ cramps ☐ irregular menstruation ☐ vaginal bleeding
☐ breast lumps/pain ☐ frequent urination ☐ pregnancy ☐ vaginal discharge
☐ burning urination ☐ hormone therapy ☐ urine retention

Male: ☐ I DENY having any of the symptoms or problems listed below.

☐ burning urination ☐ frequent urination ☐ prostate problems
☐ erectile dysfunction ☐ hesitancy/ dribbling ☐ urine retention

Endocrine: ☐ I DENY having any of the symptoms or problems listed below.

☐ cold intolerance ☐ excessive hunger ☐ goiter ☐ unusual hair growth
☐ diabetes ☐ excessive thirst ☐ hair loss ☐ voice changes
☐ excessive appetite ☐ abnormal frequency of urination ☐ heat intolerance

Skin: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ changes in nail texture	☐ hair loss	☐ itching	☐ skin lesions / ulcers
☐ changes in skin color	☐ hives	☐ paresthesias	☐ varicosities
☐ hair growth	☐ history of skin disorders	☐ rash	

Nervous System: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ dizziness	☐ limb weakness	☐ numbness	☐ slurred speech	☐ tremor
☐ facial weakness	☐ loss of consciousness	☐ seizures	☐ stress	☐ unsteadiness of gait/ loss of balance
☐ headache	☐ loss of memory	☐ sleep disturbance	☐ strokes	

Psychologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anhedonia	☐ behavioral change	☐ convulsions	☐ memory loss
☐ anxiety	☐ bi-polar disorder	☐ depression	☐ mood change
☐ loss or change in appetite	☐ confusion	☐ insomnia	

Allergy: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anaphalaxis	☐ itching	☐ chronic nasal congestion	☐ sneezing
☐ food intolerance	☐ acute nasal congestion	☐ rash	

Hematologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anemia	☐ blood clotting	☐ bruising easily	☐ lymph node swelling
☐ bleeding	☐ blood transfusion	☐ fatigue	

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for Same Condition: ☐ **I have not seen a doctor for this condition OR Fill in the information BELOW**

Have you seen other doctors for THIS CONDITION? ☐ **Yes** ☐ **No.** **If yes, Who?** (Name) _____

Type of Treatment: _____ **Was the treatment beneficial in resolving condition?** ☐ **Yes** ☐ **No**

Explain: _____

Previous Chiropractic Care: ☐ **I have not previously seen a Chiropractor OR Fill in the information BELOW.**

Doctor's Name: _____ **Location:** _____ **Date of Last Visit:** _____

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illness (es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

☐ ADD	☐ chicken pox	☐ headaches	☐ scoliosis
☐ atopic dermatitis (eczema)	☐ crohn's/colitis	☐ hepatitis	☐ seizure disorder
☐ allergies/hayfever	☐ depression	☐ HIV	☐ sickle cell anemia
☐ anemia	☐ diabetes	☐ measles	☐ spina bifida
☐ asthma	☐ ear infections	☐ mumps	☐ other:
☐ bedwetting	☐ fetal drug exposure	☐ psoriasis	
☐ cerebral palsy	☐ food allergies (list below)	☐ rash	

Adult Illness(es): LIST all health conditions. CIRCLE all CURRENT conditions.

☐ ADD	☐ cystic kidney disease	☐ hypertension	☐ psychiatric problems
☐ alzheimers	☐ depression	☐ influenzal pneumonia	☐ scoliosis
☐ anemia	☐ diabetes (insulin dep)	☐ liver disease	☐ seizures
☐ arthritis	☐ diabetes (non insulin)	☐ lung disease	☐ shingles
☐ asthma	☐ eczema	☐ lupus erythema (discoid)	☐ past history of similar symptoms
☐ cancer	☐ emphysema	☐ lupus erythema (systemic)	☐ STD's (unspecified)
☐ cerebral palsy	☐ eye problems	☐ multiple sclerosis	☐ suicide attempt(s)
☐ chicken pox	☐ fibromyalgia	☐ parkinson's disease	☐ thyroid problems
☐ crohn's/colitis	☐ heart disease	☐ unspecified pleural effusion	☐ vertigo
☐ CRPS (RSD)	☐ hepatitis	☐ pneumonia	☐ other:
☐ CVA (stroke)	☐ HIV	☐ psoriasis	

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? ☐ yes or ☐ no.

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

☐ angioplasty	☐ cosmetic	☐ hysterectomy	☐ pacemaker insertion
☐ appendectomy	☐ D & C	☐ joint reconstruction	☐ rotator cuff
☐ caesarian section	☐ dental surgery	☐ joint replacement	☐ spinal fusion
☐ cardiac catheterization	☐ gall bladder	☐ knee repair	☐ tonsilectomy
☐ carpal tunnel repair	☐ hemorrhoidectomy	☐ laminectomy	☐ other:
☐ coronary artery bypass	☐ hernia repair	☐ mastectomy	

Injury (ies): **Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

☐ back injury	☐ head injury (loss of consciousness)	☐ motor vehicle accident
☐ broken bones	☐ head injury (no loss of consciousness)	☐ soft tissue injury (mild)
☐ disability (ies)	☐ industrial accident	☐ soft tissue injury (moderate)
☐ fall (severe)	☐ joint injury	☐ soft tissue injury (severe)
☐ fracture	☐ laceration (severe)	☐ other:

Family History: **Mark all that apply below. List any specific conditions past or present after has/had:**

general family	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
father	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
mother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
paternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
paternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
maternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
maternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
son (s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
daughter(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
brother(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
sister(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____

Social History

Alcohol: ☐ Never ☐ Social Consumption only ☐ Beer ☐ Liquor ☐ Wine ; _____ oz ____ glasses; ☐ Day ☐ Week ☐ Month

Diet (please mark all that apply): ☐ High Fat ☐ High Fiber ☐ High Protein ☐ High Salt ☐ Low Calorie ☐ Low Carb ☐ Low Fiber ☐ Low Salt ☐ Low Sugar

Education (please mark the highest level completed): ☐ Preschool ☐ Elementary ☐ Middle ☐ Junior High ☐ Votech ☐ In High School ☐ Did Not Finish High School ☐ High School Diploma ☐ Post High School Classes ☐ Assoc/Technical Degree ☐ In College ☐ College Degree ☐ In Graduate School ☐ Graduate Degree ☐ Doctorate ☐ Other: _____

Drugs: ☐ Deny any illegal drug use ☐ Deny use of IV drugs ☐ Have not used drugs since _____ ☐ Have used drugs for _____

Tobacco: ☐ Deny Tobacco Use ☐ Do not smoke cigars, cigarettes or pipe ☐ Live with a smoker ☐ Quit smoking

☐ Smoke; # _____ per ☐ Day ☐ Week ☐ Month ☐ Chew; #_____cans per ☐ Day ☐ Week ☐ Year

Height:_____ Weight:_____