NANNIS CHIROPRACTIC FAMILY HEALTH CENTER

PATIENT INFORMATION FORM

[ ] Female
[ ] Male

Name: _____Nick Name: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

E-Mail Address: _____ Date of Birth: _____/_____/_____ Age: ____

Social Security #: _____Employer: _____ Occupation: _____

Driver License #:_____ State: _____ Referred by: _____

How did you hear about us? [ ] Search Engine [ ] Insurance Web Site [ ] Print Ad [ ] Flyer [ ] Event [ ] Social Network Site [ ] _____

Marital Status: (check) [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Spouse's Name: _____ Spouse's Social Security _____

Spouse's Date of Birth ____/____/_____ Spouse's Employer: _____

Name and age of children: _____

Name of Nearest Relative Not Living With You: _____ Phone: _____

(If Under 18) Name of Parent or Guardian: _____

Parent of Guardian Home Phone: _____ Work Phone: _____

Past Medical History

Have you seen another doctor for this condition [ ] yes [ ] no If yes who? _____

Previous Doctor of Chiropractic care? Dr._____ Phone: _____When was your last visit? _____

Approximately how many previous chiropractic adjustments have you received? _____

Who is your family physician? Dr. _____Phone:_____ When was your last visit? _____

What non-prescription drugs are you taking? _____

What prescription drugs are you taking? _____

Please list any surgeries: _____

_____

Have you ever broken any bones? [ ] yes [ ] no
If yes explain: _____

_____

Do you have any congenital and or birth conditions [ ] yes [ ] no
If yes explain: _____

Allergies Please list any allergies:

_____

_____

_____

Have you had any of the following diseases?

[ ] Anemia [ ] Autism* [ ] A.D.H.D.* [ ] A.D.D.* [ ] Chronic Fatigue* [ ] Epilepsy
[ ] Asthma* [ ] Heart Disease [ ] Psoriatic Arthritis* [ ] Gouty Arthritis* [ ] Rheumatoid Arthritis* [ ] Cancer
[ ] Mental Disorder [ ] Liver Disease [ ] Polio [ ] Tuberculosis [ ] Diabetes* [ ] AIDS/HIV
[ ] Kidney Disease [ ] Auto Immune Disorder* [ ] Multiple Chemical Sensitivities* [ ] O.C.D.
Other: _____

What makes you feel better?

_____

What makes you feel worse?

_____

Have you missed work because of your condition? [ ] Yes [ ] No If yes when? _____
Are your WORK activities restricted? [ ] Yes [ ] No If yes explain: _____
Are your RECREATION activities restricted [ ] Yes [ ] No If yes explain: _____

Lifestyle

How often do you

Perform Aerobic Exercise (Run/Walk/Classes/ Machines)	Daily	3X/wk	1X/wk	2X/mt	1X/mt	Never
Perform Resistance Exercise (Free Weights/Nautilus Machines)	Daily	3X/wk	1X/wk	2X/mt	1X/mt	Never
Perform Stretching Exercise (Yoga, Palates, Stretching)	Daily	3X/wk	1X/wk	2X/mt	1X/mt	Never
Use a Sauna	Daily	3X/wk	1X/wk	2X/mt	1X/mt	Never

How many hours per day do you

Work on a computer: _____
Sit at a desk: _____
Work on the phone: _____
Watch TV: _____
Perform Manuel Labor: _____
Care for Children or Elderly: _____

How old is your mattress? _____
What sports do you participate in?
_____
_____
_____
_____

Family History

	Back	Heart	Stroke	Cancer	Diabetes	High blood Pressure	Other
Mother	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	_____
Father	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	_____
Sibling # ___	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	_____

Toxicity Assessment

How many **fast food** meals do you consume each week?	□ None	□ 1-2 meals	□ 3 or more meals
How many **packaged food/frozen foods** do you eat each week?	□ None	□ 1-2 meals	□ 3 or more meals
How many **pre-prepared sauces** do you use each week? (ketchup/soy sauce/etc)	□ None	□ 1-2 meals	□ 3 or more meals
How many **refined carbohydrates** do you eat each week? (Breads/Cakes/etc)	□ None	□ 1-2 meals	□ 3 or more meals
How many **non-organic meat or eggs** do you eat each week?	□ None	□ 1-2 meals	□ 3 or more meals
How many cups **of ice tea, cola, or coffee** do you drink each week?	□ None	□ 1-2 meals	□ 3 or more meals
How many **alcoholic beverages** do you drink each week?	□ None	□ 1-2 meals	□ 3 or more meals

Do you travel by air plane? □ Never □ Under 10,000mi/yr □ Over 10,000mi/yr

Do you smoke or live with someone who does?	□ Yes	□ No
Do you use a microwave?	□ Yes	□ No
Do you reheat food in plastic?	□ Yes	□ No
Do you use a cell phone?	□ Yes	□ No
Do you live or work in an air conditioned building	□ Yes	□ No
Do you take any prescription medication?	□ Yes	□ No
Do you take any non-prescription medication?	□ Yes	□ No
Have you ever received a vaccine?	□ Yes	□ No

Do you eat organic green, leafy vegetables?	□ Yes □ No
Do you take antioxidant?	□ Yes □ No
Do you take Omega 3 fatty acids?	□ Yes □ No
Do eat 5-7 fruits/vegetables every day?	□ Yes □ No
Do you use fresh herbs in you cooking?	□ Yes □ No
Do you use air purifiers?	□ Yes □ No
Do you use a water filter?	□ Yes □ No
Do you consume at least 8 glasses of water each day?	□ Yes □ No

Which of the following body signals have you experienced in the last 6 months? (check all that apply)

EYES
[ ] Crossed Eyes
[ ] Double Vision
[ ] Vision Flashes/Halos
[ ] Red Swollen Eyes
[ ] Blurred Vision
[ ] Bag under Eyes

EARS/NOSE/THROAT
[ ] Earache
[ ] Ear Discharge
[ ] Ringing in Ear
[ ] Itchy Ears
[ ] Loss of Hearing
[ ] Hay Fever
[ ] Sinus Problems
[ ] Nose Bleeding
[ ] Gums Bleeding
[ ] Difficulty Swallowing
[ ] Persistent Cough

RESPIRATORY
[ ] Shortness of Breath
[ ] Cough [ ] Congestion
[ ] Distress [ ] Sputum
[ ] Wheezing

GENITO-URINARY
[ ] Blood in Urine
[ ] Frequent Urination
[ ] Lack of Bladder Control
[ ] Painful Urination

ENDOCRINE
[ ] Weight Gain
[ ] Weight Loss
[ ] Hoarseness
[ ] Heat Intolerance
[ ] Cold Intolerance
[ ] Breast Changes
[ ] Hair Changes
[ ] Extreme Thirst
[ ] Fever
[ ] Sweats
[ ] Light Bothers Eyes

GASTROINTESTINAL
[ ] Appetite Poor
[ ] Bloating
[ ] Bowel Changes
[ ] Constipation
[ ] Diarrhea
[ ] Excessive Hunger
[ ] Excessive Thirst
[ ] Gas
[ ] Hemorrhoids
[ ] Indigestion
[ ] Nausea
[ ] Rectal Bleeding
[ ] Stomach Pain
[ ] Vomiting No Blood
[ ] Vomiting Blood

CARDIOVASCULAR
[ ] Chest Pain *
[ ] High Blood Pressure
[ ] Irregular Heart Beat *
[ ] Low Blood Pressure
[ ] Poor Circulation
[ ] Rapid Heart Beat *
[ ] Swelling of Ankles
[ ] Varicose Veins

WOMEN ONLY
[ ] Abnormal Pap Smear
[ ] Bleeding between Periods
[ ] Breast Lumps
[ ] Extreme Menstrual Pain
[ ] Hot Flashes
[ ] Nipples Discharge
[ ] Painful Intercourse
[ ] Vaginal Discharge
[ ] Yeast Infection

MEN ONLY
[ ] Breast Lumps
[ ] Erection Difficulties
[ ] Lump in Testicles
[ ] Penis Discharge
[ ] Sore on Penis

INTEGUMENTARY
[ ] Bruise Easy
[ ] Acne
[ ] Change in Moles
[ ] Sores won't Heal
[ ] Itching
[ ] Unusual Swelling
[ ] Sores/Ulcers
[ ] Rash/Hives/Dry Skin
[ ] Scars
[ ] Psoriasis*
[ ] Eczema*

NEUROLOGICAL
[ ] Chills
[ ] Dizziness
[ ] Fainting
[ ] Loss of sleep
[ ] Seizures
[ ] Vertigo
[ ] Hand Trembling
[ ] Loss of Sensation
[ ] Loss of Facial Expression
[ ] Week Grip
[ ] Paralysis
[ ] Difficulty of Speech
[ ] Tingling
[ ] Loss of Memory
[ ] Numbness
[ ] Un-coordination

PSYCHIATRIC
[ ] Hyperventilation
[ ] Insecurity
[ ] Depression *
[ ] Trouble Sleeping
[ ] Irritable
[ ] Anxiousness
[ ] Un-decidedness
[ ] Timid
[ ] Mood Swings
[ ] Hallucinations
[ ] Loss of Memory
[ ] Nervousness
[ ] Confusion
[ ] Learning Disabilities
[ ] Alcoholism
[ ] Drug Addiction
[ ] Drug Dependency
[ ] Extreme Worry
[ ] Sexual Problems
[ ] Suicidal Thoughts

MUSCULSKELETAL

Numbness	Pain	Pins& Needles	Stiffness	
[ ]	[ ]	[ ]	[ ]	Head
[ ]	[ ]	[ ]	[ ]	Neck
[ ]	[ ]	[ ]	[ ]	Upper back
[ ]	[ ]	[ ]	[ ]	Mid Back
[ ]	[ ]	[ ]	[ ]	Lower Back
[ ]	[ ]	[ ]	[ ]	Arms
[ ]	[ ]	[ ]	[ ]	Hands
[ ]	[ ]	[ ]	[ ]	Legs
[ ]	[ ]	[ ]	[ ]	Feet
[ ]	[ ]	[ ]	[ ]	Jaw

CONSENT FOR TREATMENT/TERMS OF ACCEPTANCE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Ray L. Nannis and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Ray L. Nannis, including those working at the clinic or office located at 1600 N. Plano Road, Suite 1000, Richardson, Texas, or any other clinic, whether signatories to this form or not.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests

When a patient seeks chiropractic health care and is accepted as a patient for such care, it is essential for both the patient and the doctor to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I understand that all records and x-rays taken in this office are the property of Nannis Chiropractic Family Health Center.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient signature_____Date_____

Guardian/Representative signature_____

Office signature_____Date_____

PREGNANCY AFFIRMATION

I affirm, to the best of my knowledge that I am not currently pregnant. Should this condition change I will notify Dr. Nannis and/or his staff as soon as possible.

Date of Last Menstrual Period_____

Patient Signature_____Date_____

Guardian/Representative signature_____