

**INITIAL HEALTH STATUS**

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: M / F  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver Lic. #: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Insured Name: \_\_\_\_\_ Health Plan: \_\_\_\_\_  
 Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Insured Birthdate: \_\_\_\_\_  
 Insured Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Primary Care Physician Name: \_\_\_\_\_ PCP Phone: \_\_\_\_\_

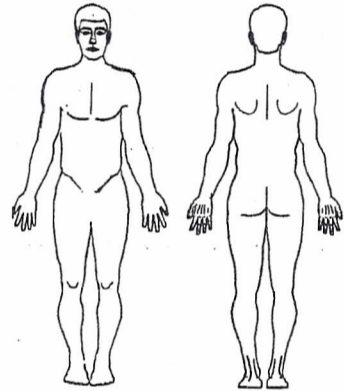
MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

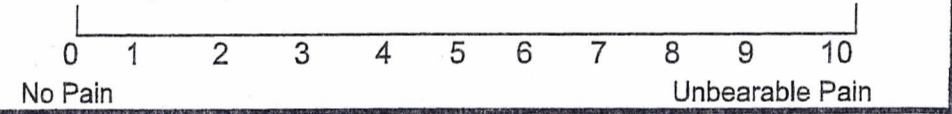
\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is this?  Work Related  Auto Related  N/A

**DATE PROBLEM BEGAN:** \_\_\_\_\_



Current complaint (how you feel today):



How often are your symptoms present?  0 - 25%  26 - 50%  51 - 75%  76 - 100%  
 Can you perform your daily activities?  Yes  No (Describe) \_\_\_\_\_

**HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN?**  No  Yes Date(s) taken: \_\_\_\_\_

**WHAT AREAS WERE TAKEN?**

Please check all of the following that apply to you:  None Apply

- | No                       | Yes                      | Condition                   |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever                |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use          |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills         |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure         |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting          |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks  |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention           |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor                |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis                |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma               |

- | No                       | Yes                      | Condition                                                                   |
|--------------------------|--------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems                                                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination                                                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____                                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures                                                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances                                                         |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain                                                |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain                                                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use                                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use                                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____                                                |
|                          |                          | _____                                                                       |
|                          |                          | _____                                                                       |

Family History:  Cancer  Diabetes  High Blood Pressure  Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that I will be responsible for charges deemed patient responsibility or non-covered by my insurance carrier. I authorize the release of any medical or other information necessary to process my insurance claims. I agree to pay any and all attorney and/or collection fees incurred as a part of the cost of collection. I also agree to pay a minimum finance charge of 1.5% per month (APR of 18%) or a minimum of \$5.00 whichever is more on any amount not paid after 30 days. I authorize payment of medical benefits to Total Health Chiropractic (Dr. Timothy D Annis).

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_