Leath Chiropractic, LLC
11125 Highway 70 Suite 106
Arlington, TN 38002
901-867-1001(p) 901-867-1661(f)
www.leathchiropractic.com

HEALTH REPORT:

Name:____
Age:______________________ DOB:___________________________ SS#___________________________________
Address:____ City:__________________ State: _____ Zip:____________
Phone: Home:__________________ Cell:____________________ E-Mail:_____________________________________
Marrital status: __Single __Married __Divorced __Separated __Widowed
Work: __Full Time __Part Time __Retired __Unemployed __Student (full time) __Student (Part Time)

Present condition due to an injury? __ Yes __ No Type? __ On the Job __ Auto Accident __ Other
Has the accident been reported? __ Yes __ No To Whom? __ Employer __ Auto Carrier __ Other
Who may we thank for your referral (include advertisement if appropriate)?_____________________________________
Reason(s) for seeking care:____
List any other doctors seen for this: ____
List any diagnosis and type of treatment: ____
____
List any current medications taken for this condition (include OTC medications):___________________________________
____
How and when did your complaint(s) start? ____
____
How did each area feel at the time of injury? (intensity=1-10, type= sharp, dull, burning, aching, numb, etc.
frequency=% of time symptoms were present): ____
____
____
How does it feel today? (intensity=1-10, type= sharp, dull, burning, aching, numb, etc. frequency=% of time symptoms were present): ____
____
____
List anything that seems to worsen your condition(s): ____
____
List anything that has provided relief: ____
____
List any accidents or injuries you have had: ____
____
____
Have you received chiropractic treatment previously? __ Yes __ No If yes, explain:_________________________
____
____
Have you been treated for any health condition by a physician in the last year? __ Yes __ No If yes, explain: ______
____
____
Name of Physician(s):____
____
Are you currently taking medication not listed above? __ Yes __ No
List: ____
____
Have you taken medication(s) in the past? __ Yes __ No
List:____
____
List surgeries and approximate dates: ____
____
List any food, environmental, or medication allergies: ____
____

Patient Name:____________________________________ Number:______________ Date:______________

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Family History: Health conditions, age of death and cause of death.
Father: ____
Mother: ____
Brother(s) & Sister(s):____
Do you smoke? __Yes __No How much do you smoke? _______cigarettes per day _______cigars per _______
Do you drink alcohol? __Yes __No If yes, how often? __Daily __Weekly __Social Occasions
Do you take Vitamins/Supplements? __Yes __No If yes, type and how often _________________________________
____

Please circle degree of pain, 0 none, 10 severe pain.
(none) 0 1 2 3 4 5 6 7 8 9 10 (severe)
Area:______________________________________
(none) 0 1 2 3 4 5 6 7 8 9 10 (severe)
Area:______________________________________
(none) 0 1 2 3 4 5 6 7 8 9 10 (severe)
Area:______________________________________

Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other ______	^ ^ ^

Is this condition worse during certain times of the day? _____________________
Is this condition interfering with: ___Work ___Sleep ___Routine ___Other? _________________________________
Is this condition getting: __better ___worse ___unchanged

Office Use Only: ____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Doctor's signature:______________________________________ Date:_____________________

Patient Name:____ Number:______________ Date:______________

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Please mark each item below for each sign or symptom you have now or have had in the past:

GENERAL SYMPTOMS
__Now__Past Convulsions
__Now__Past Dizziness
__Now__Past Fainting
__Now__Past Headache/Migrane
__Now__Past Nervousness
__Now__Past Numbness
__Now__Past Wheezing
__Now__Past Anxiety
__Now__Past Depression
__Now__Past Drug Addiction
__Now__Past Alcoholism
__Now__Past Mental Illness
__Now__Past Diabetes

MUSCLES & JOINTS
__Now__Past Low Back Pain
__Now__Past Mid Back Pain
__Now__Past Neck Pain
__Now__Past Arm Problems
__Now__Past Leg Problems
__Now__Past Swollen Joints
__Now__Past Painful Joints
__Now__Past Stiff Joints
__Now__Past Sore Muscles
__Now__Past Weak Muscles
__Now__Past Walking Problems
__Now__Past Sprains/Strains
__Now__Past Broken Bones

CARDIOVASCULAR
__Now__Past High Blood Pressure
__Now__Past Heart Attack
__Now__Past Pain over Heart
__Now__Past Poor Circulation
__Now__Past Heart Trouble
__Now__Past Rapid Heart
__Now__Past Slow Heart
__Now__Past Strokes
__Now__Past Swelling Ankles
__Now__Past Varicose Veins

EYE/EAR/NOSE/THROAT
Last Eye Exam:__________________
__Now__Past Glasses/Contacts
__Now__Past Pain Behind Eyes
__Now__Past Cataracts
__Now__Past Earache
__Now__Past Difficulty Hearing
__Now__Past Ear Noises
__Now__Past Enlarged Thyroid
__Now__Past Frequent Colds
__Now__Past Hay Fever
__Now__Past Nasal Blockage
__Now__Past Nose Bleeds
__Now__Past Sinusitis
__Now__Past Sore Throats
__Now__Past Tonsillitis

GASTROINTESTINAL
__Now__Past Belching/Gas
__Now__Past Indigestion
__Now__Past Colon Problems
__Now__Past Constipation
__Now__Past Diarrhea
__Now__Past Excessive Hunger
__Now__Past Excessive Thirst
__Now__Past Hemorrhoids
__Now__Past Liver/Gallbladder
__Now__Past Nausea
__Now__Past Abdominal Pain
__Now__Past Ulcer
__Now__Past Poor Appetite
__Now__Past Poor Digestion
__Now__Past Vomiting
__Now__Past Vomiting Blood
__Now__Past Black Stool
__Now__Past Bloody Stool
__Now__Past Weight Loss/Gain

RESPIRATORY
__Now__Past Asthma
__Now__Past Chronic Cough
__Now__Past Difficulty Breathing
__Now__Past Spitting Blood
__Now__Past Spitting Phlegm

GENITOURINARY
__Now__Past Blood in Urine
__Now__Past Frequent Urination
__Now__Past Kidney Infection
__Now__Past Painful Urination
__Now__Past Prostate Problems
__Now__Past Incontinence
__Now__Past Syphilis
__Now__Past Gonorrhea
__Now__Past Other STD

SKIN OR ALLERGIES
__Now__Past Boils
__Now__Past Bruising Easily
__Now__Past Dryness
__Now__Past Eczema/Rash/Dermatitis
__Now__Past Hives
__Now__Past Itching
__Now__Past Sensitive Skin
__ Allergy ______________________

FOR WOMEN ONLY
Last Menstrual Period:____________
__ Birth Control _________________
__Now__Past Hormone Replacement
__Now__Past Cramps/Backaches
__Now__Past Excessive Flow
__Now__Past Hot Flashes
__Now__Past Irregular Cycle
__Now__Past Miscarriage
__Now__Past Painful Periods
__Now__Past Vaginal Discharge
__Now__Past Breast Pain
Pregnant at this Time **Y/N ?**

Insurance Information:
Will insurance be used as payment? ___Yes ___No
Who is responsible for payment:______________________________________ DOB.___________________________
SS#____________________________ Relationship to patient: _______________ Phone:________________________ E-mail:___________________________________ Occupation: ____
Home Address (if different):________________________________ City:______________ State___ Zip:___________
Name of primary insurance: ____
Insurance Id#:_______________________________________ Group#:____
Name of secondary insurance:____
Insurance Id#:_______________________________________ Group#:____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient Signature____Date__________________________

Patient Name:____________________________________ Number:______________ Date:______________