

CONFIDENTIAL PATIENT INFORMATION FORM

Dr. Michael B. Ackerman, D.C.

Name [Mr., Mrs., Ms., Dr.] _____ Date _____ E-mail _____
Address _____ City _____ State _____ Zip _____
Home Phone () _____ Cell Phone () _____ Birthdate _____ Age _____
Employer _____ Occupation _____ Work Phone () _____
Marital Status: M S W D How many children: _____ Soc. Sec. No. _____ - _____ - _____
Name of spouse _____ Spouse's Occupation _____
Spouse's employer _____ Spouse's Work Phone() _____
Patient's nearest relative _____ Relationship _____ Phone() _____
Referred by _____ Date symptoms appeared or accident happened _____
Is condition due to injury or illness arising from your employment? Yes No
If so, did you report this condition to your work supervisor? Yes No Number of days lost from work _____
Has the patient ever had the same or similar condition? Yes No If Yes, describe _____

Date of last physical examination _____ Reason? _____
Doctor's name _____ What was the diagnosis? _____

Females: Is there a chance that you could be pregnant? Yes No Date of last normal menstrual period: _____
What operations have you had, include age at time? _____

What medical illnesses have you had, include age at time of illness? _____

Previous history of accidents or injuries for which you sought treatment, include age at time? _____

Have you ever been under chiropractic care? Yes No Reason: _____

Previous chiropractor? _____ Frequency (Times/Mo) _____ Date of last treatment? _____

Have you ever suffered from any of the following: **N=I** have it **Now** **P=I** had it in the **Past** **F= Family History**

| N P F | N P F | N P F | N P F |
|--|---|--|---|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> A.I.D.S. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor postural habits | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sciatica | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruise easily | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Head injury | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal curvatures | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bladder/Urination |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen joints | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue/loss of sleep | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon trouble | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus infections | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate trouble |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ulcers | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anxiety | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult digestion |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Depression | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver problems | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Flatulence or belching |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pains | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Breast/Gynecolg. prob. |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart problems | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot flashes | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cancer/Lymphoma | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abnormal heart beat | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fevers/rheumatic fever |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low back pain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Circulation | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arm/hand problems | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Leg/foot problems |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stroke/T.I.A.s | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck pain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Coughing | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid weight change | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling of ankles |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bursitis | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Venereal Diseases | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Memory loss | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eating disorders | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Weakness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye/vision problems | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear/hearing problems |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Infection | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Inflammation | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Circulation |

Have you ever had tingling, shooting pains, or numbness in any of the following areas:

| Now | Past | Now | Past |
|--------------------------|--------------------------|---------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulders | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Hips | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Arms | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Thighs | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbows/wrists | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Legs/ankles | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Hands | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Feet | <input type="checkbox"/> |

HABITS: H=Heavy M=Moderate L=Light N=None P=Past

| | H | M | L | N | P |
|----------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Caffeine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Drugs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Appetite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Do you take vitamin or mineral supplements? Yes No
Do you think you may need supplements? Yes No

Do you ever sleep on your stomach? Yes [] No []

Do you wear or use any type of corrective supports for your...

Neck Back Shoulders, Elbows, Wrists Knees, Ankles, Feet Teeth/Jaws, **Pillow Type?** _____

