Oakwood Chiropractic & Wellness
Dr. Stuart J. Yeager
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Confidential Patient History

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we do not accept your case. Thank you.

NAME_____ SEX M/F _____ DATE_____ AGE_____
ADDRESS_____ CITY_____ STATE_____ ZIP_____
BIRTH DATE_____ S.S.#_____ HOME PHONE_____
WORK PHONE_____ CELL PHONE_____ MARITAL STATUS S/M/D
SPOUSE_____ WHO IS RESPONSIBLE FOR THIS ACCOUNT_____
EMERGENCY CONTACT_____ PHONE #_____ EMAIL_____
REFERRED BY_____ Yellow Pages Advertisement Insurance Plan Other_____

Please check the appropriate box for any of the following symptoms you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL REPORT.

N- now present
P- past experienced

N P	N P	N P	N P	N P
0 0 Dizziness	**Pain or numbness in**	0 0 Earache	**SKIN**	**WOMEN ONLY**
0 0 Drop attacks (fainting)	0 0 shoulders	0 0 Ear discharge	0 0 Boils	0 0 Congested breasts
0 0 Diplopia (visual disturbances)	0 0 Arms	0 0 Ear noises/ Tinnitis	0 0 Bruise easily	0 0 cramps or aches
0 0 Dysarthia (difficulty speaking)	0 0 Elbows	0 0 Enlarged glands	0 0 Dryness	0 0 excessive menstrual flow
0 0 Dysphasia (difficulty swallowing)	0 0 Hands	0 0 Enlarged thyroid	0 0 Hives or allergy	0 0 Hot flashes
0 0 Ataxia (difficulty walking)	0 0 Hips	0 0 Eye pain	0 0 Itching	0 0 Irregular cycle
0 0 Nausea	0 0 Legs	0 0 Failing vision	0 0 Skin eruptions	0 0 menopausal symptoms
0 0 Numbness	0 0 Knees	0 0 Gum trouble	0 0 Varicose veins	0 0 Painful menstruation
0 0 Allergy	0 0 Feet	0 0 Hay fever	**GENITO-URINARY**	0 0 Vaginal discharge
0 0 Chills	**GASTRO-INTESTINAL**	0 0 Hoarseness	0 0 Bed wetting	
0 0 Convulsions	0 0 Belching or gas	0 0 Nasal obstruction	0 0 Blood in urine	
0 0 Fatigue	0 0 Colon trouble	0 0 Nosebleeds	0 0 Frequent urination	
0 0 Fever	0 0 Constipation	0 0 Sinus infection	0 0 Incontinence (bladder cont.)	
0 0 Headache	0 0 Diarrhea	0 0 Sore throat	0 0 Nervousness	
0 0 Loss of sleep	0 0 Difficult digestion	0 0 Tonsillitis	infection	
0 0 Loss of weight	0 0 Distention of abdomen	**CARDIO- VASCULAR**	0 0 painful urination	
0 0 Excessive hunger	0 0 Hardening of the arteries	0 0 Kidney stones	0 0 prostate trouble	
0 0 Sweats	0 0 Gall bladder trouble	0 0 High blood pressure	0 0 pus in urine	
0 0 Anxiety	0 0 Hemorrhoids	0 0 Low blood pressure		
0 0 Depression	0 0 Intestinal Worms	0 0 Pain over heart		
MUSCLE & JOINT	0 0 Jaundice	0 0 Poor circulation		
0 0 Arthritis	0 0 Liver trouble	0 0 Rapid heart beat		
0 0 Bursitis	0 0 Pain over stomach	0 0 Slow heart beat		
0 0 Foot trouble	0 0 Poor appetite	0 0 Swelling of ankles		
0 0 Hernia	0 0 Vomiting	**RESPIRATION**		
0 0 Low back pain	0 0 Vomiting blood	0 0 Chest pain		
0 0 Neck pain/stiffness	**EYES/EARS/NOSE/THROAT**	0 0 Chronic cough		
0 0 Pain between shoulders	0 0 Asthma	0 0 Difficult breathing		
0 0 Painful tail bone	0 0 Colds	0 0 Spitting up blood		
0 0 Sciatica	0 0 Crossed eyes	0 0 Spitting up phlegm		
0 0 Spinal Curvature	0 0 Deafness	0 0 Wheezing		
0 0 Swollen joints	0 0 Dental decay			

Are you pregnant: Y/N
List pregnancies:
_____ births
_____miscarriages

CHECK ANY CONDITONS YOU HAVE HAD:

0 Alcoholism	0 Diabetes	0 Gout	0 Pleurisy	0 Typhoid fever
0 Anemia	0 Diphtheria	0 Heart disease	0 Pneumonia	0 Ulcers
0 Appendicitis	0 Eczema	0 Influenza	0 Polio	0 Venereal disease
0 Arteriosclerosis	0 Emphysema	0 Malaria	0 Rheumatic fever	0 Whooping cough
0 Arthritis	0 Epilepsy	0 Measles	0 Scarlet fever	
0 Cancer	0 Fever blisters	0 Multiple Sclerosis	0 Stroke	
0 Cold sores	0 Goiter	0 Mumps	0 Tuberculosis	

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1. What is your major complaint?
2. What does this complaint keep you from doing?
3. How long have you had this condition? Have you had a similar condition in the past?
4. What aggravates this condition?
5. Is this condition getting progressively worse? () yes () no () constant () comes and goes
6. Is this condition interfering with your: () work () sleep () daily routine () other
7. List previous diagnoses and/or treatments that you have received for this condition.
8. Other complaints?
9. What do you believe is wrong with you?
10. List all surgical operations you have had and when.
11. Drugs you now take.
    () nerve pills () pain killers () muscle relaxors () "pep" pills () tranquilizers () birth control () others

12. Have you ever had oral surgery? ()yes () no
13. Are you wearing: () sole lifts () heel lifts () inner soles () arch supports
14. Have you been in an auto accident? () past year () past 5 years () over 5 years () never
    Describe

15.. F AMIL Y HEALTH HISTORY-Many health problems are a result of hereditary weakness, thus information about your family will give us a better idea of your total health picture.
Side of the family (mother or father) Relation Past and Present Health Problems

16. Have you ever been:

YES NO Knocked unconscious

YES NO Been treated for a spine or nerve disorder

YES NO Had a fractured bone

YES NO Been hospitalized

17. Do you ever:

Take vitamins and minerals? _____

_____

Have an allergy to any drug? _____

18. Have you ever have previous chiropractic care? YES NO Where?_____

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Consent to treatment I agree to be treated by Dr. Yeager and technicians for my health questions and health concerns. This treatment will include, but no be limited to, chiropractic care including adjustments, myofascial therapy, intersegmental traction, percussive massage, micro current therapy, and more. I also understand assessments through applied kinesiology and meridian stress assessment testing along with general muscle testing.

I understand that this is not a guarantee to a cure for any condition but do understand that the body has the ability to heal itself and that the treatments given will help enable the body to heal. I understand that I am not being treated for cancer, diabetes or any other life threatening condition, but may be treated for the pain and discomfort of these possible conditions. I understand that it is my responsibility to inform Dr. Yeager of any changes in my health condition. I also understand that the staff of Dr. Yeager will not advise me on the use or change of any prescription medication I may be taking.

I agree to follow any information or data relating to my case to be used for future research/statistical purposes. Any personal identifying information from my case will be strictly confidential and my personal privacy will be protected. I understand that occasionally visiting doctors and or staff to the clinic may be present for the observation of my care.

Patient Name (printed) _____

Patient's Signature_____ Date_____

Guardian or Spouse's Signature Authorizing Care_____ Date_____