Miller Chiropractic Health Center

13470 S. Arapaho, Suite 150 Olathe, KS 66062 (913) 782-7260

Health History & Neurotoxic Questionnaire

Patient: **Today's Date: _____**

Last Name: _____ First Name: _____ Middle: _____

Gender: M F Date of Birth: ____/____/____ Age: _____ Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Partnership

Home Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

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

Employer Name: _____ Occupation: _____

Employer Address: _____

Who referred you to our office? _____

E-mail address: _____

EMERGENCY: Name and address of person to contact in case of an emergency

Last Name: _____ First Name: _____ Middle: _____

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

Relationship to Patient: _____

SPOUSE/GUARDIAN/RESPONSIBLE PARTY:

Last Name: _____ First Name: _____ Middle: _____

Employer Name: _____ Cell Phone #: _____

Date of Birth: ____/____/____ SS #: _____ Work Phone # _____

What is your major complaint and when did these symptoms begin?

_____

_____

_____

_____

_____

_____

What are your current medications?

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

What are your current vitamins and/or supplements?

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list past or present allergies, including allergies to medications.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list all past surgeries and the condition each surgery was for and the year it was performed.

_____

_____

_____

_____

_____

WOMEN ONLY:

To your knowledge, are you pregnant?	□ Yes	□ No
Have your past pregnancies been normal?	□ Yes	□ No
Have you had a miscarriage?	□ Yes	□ No
Are you seeing an OB-GYN regularly?	□ Yes	□ No

Date of last exam: _____ **Physician's name and address:** _____

_____

_____

REVIEW OF SYSTEMS **Are you presently suffering (or within the past six months have suffered) from any of the following?** (Please check "normal" if there are no issues with that system.)	
General:	□ Normal □ Fatigue □ Weakness □ Fever □ Loss of sleep □ Chills □ Weight change □ Night sweats □ Other _____
Skin:	□ Normal □ Rash □ Redness □ Itching □ Dryness □ Eczema □ Hair changes □ Nail changes □ Bruise easily □ Other _____
Neurological:	□ Normal □ Headache □ Dizziness □ Fainting □ Convulsions □ Nervousness □ Other _____
Eyes:	□ Normal □ Vision trouble □ Pain □ Discharge □ Other _____
Ears:	□ Normal □ Hearing trouble □ Ringing □ Pain □ Discharge □ Other _____
Nose:	□ Normal □ Pain □ Bleeding □ Sinus Problems □ Infections □ Absence of smell □ Other _____
Mouth/Throat:	□ Normal □ Sores □ Bleeding □ Enlarged glands □ Absence of taste □ Abnormal taste □ Tonsillitis □ Other _____
Cardio-Vascular-Pulmonary: (Heart/Lungs)	□ Normal □ Cough □ Wheezing □ Difficulty breathing □ Swollen extremities □ Blue extremities □ Varicosities □ Murmur □ Chest Pain □ Palpitations □ Other _____
Breasts:	□ Normal □ Lumps in breast □ Redness/Itching □ Pain □ Dimpling □ Discharge □ Other _____
Gastrointestinal: (Stomach/Digestion)	□ Normal □ Decreased appetite □ Increased appetite □ Abdominal pain □ Hemorrhoids □ Excess gas □ Vomiting □ Diarrhea □ Constipation □ Other _____

Patient History

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

Mercury

☐ Yes ☐ No Do you have amalgam (silver) fillings in your teeth?
☐ Yes ☐ No Have you ever had them in the past?
☐ Yes ☐ No Did your mother have amalgam when pregnant with you?
☐ Yes ☐ No Have you ever worked in a dental office? If so, how long? _____
☐ Yes ☐ No Have you had any dental crowns, bridges, root canals, dry sockets or infected tooth extractions?
☐ Yes ☐ No Do you have any dental implants or other metal in your mouth?
☐ Yes ☐ No Did you wear contact lenses during the 1980's or early 1990's?
☐ Yes ☐ No Did you take oral contraceptives during the 1980's or early 1990's?
☐ Yes ☐ No Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination? When was your last vaccination _____
☐ Yes ☐ No Have you noticed any adverse reactions to these shots?
☐ Yes ☐ No Do you have any tattoos with red ink?
☐ Yes ☐ No Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?

Lead

☐ Yes ☐ No Does your occupation involve soldering, metal salvage, old home repair or sandblasting?
☐ Yes ☐ No Have you remodeled a home built before 1978?
☐ Yes ☐ No Have you lived in a home built before 1978 for more than 5 years?
☐ Yes ☐ No Have you ever worn cosmetics containing kohl?

General Toxicity

☐ Yes ☐ No Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain.
☐ Yes ☐ No Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.)
☐ Yes ☐ No Do you have a water filtration system at home? What kind _____
☐ Yes ☐ No Do you have a water filtration system for your shower?

Mold

How old is the house you are living in? _____ How long have you lived there? _____
☐ Yes ☐ No Do you see mold growing at home, work or school?
☐ Yes ☐ No Have you ever had water damage at home, work or school?
☐ Yes ☐ No Does your home, workplace or school have a damp or mildew smell?
☐ Yes ☐ No Does spending time in your basement cause or worsen your symptoms?
☐ Yes ☐ No Does your basement ever get wet?
☐ Yes ☐ No Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?

Lyme Disease

☐ Yes	☐ No	Have you ever been diagnosed with Lyme disease?
☐ Yes	☐ No	Have you ever been bitten by a tick or recluse spider?
☐ Yes	☐ No	Have you ever seen a bulls-eye rash appear on any part of your body?
☐ Yes	☐ No	Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?
☐ Yes	☐ No	Was your mother ever diagnosed with Lyme Disease?
☐ Yes	☐ No	Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?

Health History

☐ Yes	☐ No	Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?
☐ Yes	☐ No	Do you have any history of kidney dysfunction?
☐ Yes	☐ No	Is there a family history of breast, uterine, cervical or other female cancers?
☐ Yes	☐ No	Is there a family history of PMS, fibroids or ovarian cysts? (Please circle all that apply)
☐ Yes	☐ No	Do you have any history of heart disease, myocardial infarction (heart attack), etc.?
☐ Yes	☐ No	Are you currently having any thoughts of suicide?
☐ Yes	☐ No	Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?
☐ Yes	☐ No	Do you have a history of strokes?
☐ Yes	☐ No	Have you ever been diagnosed with diabetes mellitus?
☐ Yes	☐ No	Have you ever been in an auto accident, fallen or received a major physical injury?
☐ Yes	☐ No	Are you in menopause?
☐ Yes	☐ No	Do you have any allergies to food or medication?
☐ Yes	☐ No	Do you use round up or other herbicides/pesticides in your yard? When was it last sprayed
☐ Yes	☐ No	When was your home last sprayed for bugs? _____

If <u>you now have</u> or <u>you have had</u> one of the following illnesses, please check <u>EITHER</u> "now have" or "have had".

Arthritis	□ Now have	□ Have had	Sexually transmitted disease	□ Now have	□ Have had
Asthma	□ Now have	□ Have had	Ulcer	□ Now have	□ Have had
Sinus trouble	□ Now have	□ Have had	Cancer	□ Now have	□ Have had
Hay fever	□ Now have	□ Have had	Polio	□ Now have	□ Have had
Allergies	□ Now have	□ Have had	Rheumatic fever	□ Now have	□ Have had
Tuberculosis	□ Now have	□ Have had	Serious injury	□ Now have	□ Have had
Diabetes	□ Now have	□ Have had	Bone fracture	□ Now have	□ Have had
Epilepsy	□ Now have	□ Have had	Dislocated joints	□ Now have	□ Have had
Thyroid trouble	□ Now have	□ Have had	Spinal disc disease	□ Now have	□ Have had
High blood pressure	□ Now have	□ Have had	Multiple sclerosis	□ Now have	□ Have had
Low blood pressure	□ Now have	□ Have had	Scoliosis	□ Now have	□ Have had
Heart trouble	□ Now have	□ Have had	Mental/Emotional difficulty	□ Now have	□ Have had
Pacemaker	□ Now have	□ Have had	Prostate trouble	□ Now have	□ Have had
HIV/ARC	□ Now have	□ Have had	Kidney trouble	□ Now have	□ Have had
AIDS	□ Now have	□ Have had	Other _____	□ Now have	□ Have had
Other _____	□ Now have	□ Have had			

NUTRITIONAL INFORMED CONSENT: All recommendations, including but not limited to, nutritional counseling, supplement recommendations, referrals and life style recommendations are for your general wellbeing and health and not a treatment for any medical condition. We will not make a medical diagnosis nor provide treatment recommendations for any medical condition. We recommend you consult with your primary health care practitioner for diagnosis and treatment of specific medical conditions or illness. Any suggested nutritional advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment. I have read and understand the above.
Signature: _____ Date: _____

PAYMENT IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.
Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. By signing this agreement you understand that you are responsible for all charges during your treatment. You also understand that if you suspend or terminate your care and treatment, any fees for professional services rendered to you will be immediately due and payable. I give Miller Chiropractic Health Center and its representatives permission to communicate to me via the contact information above.
Patient's or authorized person's signature: _____Date _____

Patient Privacy Act:

I ACKNOWLEDGE THAT I HAVE RECEIVED, REVIEWED, AND UNDERSTAND AND AGREE TO THE *Notice of Privacy Practices* of Miller Chiropractic Office, PA, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

_____ _____

Signature of patient or legal guardian **Date**

I give permission for the following persons to have full access to my medical records:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship