Miller Chiropractic Health Center

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

Health History & Neurotoxic History

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: _____

E-mail address: _____

Who may we thank for reffering you to our office? _____

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: ____/____/____ Work Phone # _____

HEALTH CONCERNS: If you have no symptoms or complaints and are here for Optimal Health & Wellness Services please skip to the next section.

Please list your health concerns according to their severity.	Rate of severity 1 = mild 10 = worst imaginable	When did THIS episode start?	If you had this condition before, when?	% of the time the pain/symptom is present
1.				
2.				
3.				
4.				
5.				

Did your symptoms start □ Suddenly? □ Progressively?

What were you doing when your symptoms started? _____

Since the problem started is it: □ About the same? □ Getting better? □ Getting worse?

_____

_____

What makes it worse? _____

What makes it better? _____

What have you done for this condition? Was it of benefit? _____

_____

Do you have a family history of these symptoms? Please explain: _____

_____

Other health care practitioners you have seen for this condition:
□ Medical Doctor □ Dentist □ Other _____
□ "Limited Scope" Chiropractor (focuses mainly on neck and back pain)
□ "Wellness Chiropractor" (focuses on health and wellbeing as well as underlying cause of pain and health concerns)

Doctor's Details:

Name:	State/City
When did you seem them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	State/City
When did you seem them?	
What did they say was wrong?	
Did it help?	What did they do?

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) if so what?

_____

_____

Is this condition interfering with any of the following?
Work □ Sleep □ Daily Routine □ Sports/exercise □ Other □ (explain)

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

Surgery	Date performed	Age at time of surgery
1.		
2.		
3.		
4.		

Have you had any accidents/injuries: auto, work-related, or other? (especially those related to your present problems?)

1. Type:	When?	Hospitalized? □ Yes □ No
2. Type:	When?	Hospitalized? □ Yes □ No
3. Type:	When?	Hospitalized? □ Yes □ No

What are your current medications and HOW LONG have you been taking them?

_____ _____
_____ _____
_____ _____
_____ _____

What are your current vitamins and/or supplements?

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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

_____ _____
_____ _____
_____ _____

NEUROTOXIC HISTORY

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

Dental

☐ Yes ☐ No Do you have amalgam (silver colored) 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 Do you have tooth colored fillings? How many_____
Were they done by a biological dentist? _____
☐ Yes ☐ No Have you ever worked in a dental office? If so, how long? _____
☐ Yes ☐ No Do you have any dental implants or other metal in your mouth?

Please List any major dental work you have had done (including crowns, bridges, root canals, wisdom teeth removal, infected tooth extractions, implants, **amalgam filling removal**, etc…)

Type of procedure	Year performed	Complications? (explain)
1.		
2.		
3.		
4.		
5.		

Environmental

☐ 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 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
☐ 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?
☐ 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?
☐ Yes ☐ No Do you frequently wear makeup?
☐ Yes ☐ No Do you frequently wear lipstick?
☐ Yes ☐ No Have you ever lived on or near a plant farm?
☐ 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? _____
☐ Yes ☐ No Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?
☐ 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 Were you breastfed? How long? _____

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)?

Please List Vaccination History: please include any allergy shots

Vaccine	List years given	Adverse Reaction (explain)
1. Childhood		
2. Flu Vaccine		
3.		
4.		
5.		
6.		

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	**Dislocated joints**	□ Now have	□ Have had
Diabetes	□ Now have	□ Have had	**Stroke**	□ Now have	□ Have had
Epilepsy	□ Now have	□ Have had	**Multiple sclerosis**	□ Now have	□ Have had
Thyroid trouble	□ Now have	□ Have had	**Scoliosis**	□ Now have	□ Have had
High blood pressure	□ Now have	□ Have had	**Mental/Emotional difficulty**	□ Now have	□ Have had
Low blood pressure	□ Now have	□ Have had	**Thoughts of Suicide**	□ Now have	□ Have had
Heart trouble	□ Now have	□ Have had	**Prostate trouble**	□ Now have	□ Have had
Pacemaker	□ Now have	□ Have had	**Kidney trouble**	□ Now have	□ Have had
HIV/AIDS	□ Now have	□ Have had	**Other** _____	□ Now have	□ Have had
Migraines	□ Now have	□ Have had	**Other** _____	□ Now have	□ Have had

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	□ Yes □ No □ Maybe
If dietary changes are indicated would you be willing to make changes in your diet?	□ Yes □ No □ Maybe
Would you take whole food supplements if indicated?	□ Yes □ No □ Maybe
If specific exercises or stretching would help, would you consider adding them to your program?	□ Yes □ No □ Maybe
If reducing stress would help, would you like to know ways to reduce stress?	□ Yes □ No □ Maybe

STRESSORS:

Because accumulation of stress affects our health and ability to heal, please list your top three stressors (you have ever had) in each category:

PHYSICAL Stress: (falls, accidents, work postures, sports etc)

1. _____
2. _____
3. _____

BIO-CHEMICAL Stress: (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc)

1. _____
2. _____
3. _____

MENTAL/emotional or psychological stress: (work, relationships, finances, self-esteem, trauma, etc)

1. _____
2. _____
3. _____

WOMEN ONLY: Please check all that apply

Are you pregnant? □ Yes □ No □ Possible
Are you in menopause? □ Yes □ No
Have you had a miscarriage? □ Yes □ No
Are you periods regular? □ Yes □ No
Are your periods heavy? □ Yes □ No Average Length? _____
If in menopause, were they regular in the past? □ Yes □ No
Have your past pregnancies been normal? □ Yes □ No (if not please explain) _____
_____
Are you seeing an OB-GYN regularly? □ Yes □ No Date of last exam: _____

On a scale of 1-10 please grade your present levels of stress (including physical, biochemical and mental):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General Health:	Mental Health:

Is there anything else which may help to better understand you which has not been discussed?

_____
_____
_____
_____
_____

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