WELCOME TO BLUE SKY HEALTH AND WELLNESS

Today's Date _____ **Please Print:**

PERSONAL INFORMATION

NAME:_____ SOCIAL SECURITY:_____ PHONE:_____

MOBILE NUMBER:_____ EMAIL ADDRESS:_____

ADDRESS:_____CITY:_____ STATE: _____ ZIP CODE:_____

AGE: _____ DATE OF BIRTH:_____ SEX: M / F MARITAL STATUS:_____ CHILDREN?_____

OCCUPATION:_____ EMPLOYER:_____

ADDRESS:_____ WORK NUMBER:_____

NAME OF SPOUSE:_____ OCCUPATION: _____ WORK NUMBER:_____

EMERGENCY CONTACT:_____ PHONE NUMBER: _____

HOW DID YOU HEAR ABOUT US?_____(Please write in name of person or event)

HEALTH HISTORY

PURPOSE OF THIS
APPOINTMENT:_____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? YES_____ NO _____ COMES AND GOES _____

HOW LONG HAS IT BEEN SINCE YOU REALLY FELT GOOD? _____

WHAT DO YOU BELIEVE IS WRONG WITH YOU?_____

WHAT POSITIONS OR ACTIVITIES AFFECT YOUR CONDITION?_____

OTHER DOCTORS SEEN FOR THIS CONDITION:_____

DO YOU TAKE ANY VITAMINS? YES___ NO ___ DO YOU THINK YOU MIGHT NEED VITAMINS OR MINERALS? YES_____ NO _____

ARE YOU WEARING HEEL LIFTS? _____, SOLE LIFTS_____ INNER SOLES _____ OR ARCH SUPPORTS_____

DO YOU HAVE TINGLING OR NUMBNESS IN : SHOULDERS___ARMS___ELBOWS___HANDS___HIPS____LEGS___KNEES___ FEET____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITIONS BY A PHYSICIAN IN THE LAST YEAR? YES____ NO ____ DESCRIBE_____

SERIOUS ILLNESS?_____

WHAT OPERATIONS HAVE YOU HAD?_____

DATE OF LAST PHYSICAL:_____ FEMALE: ARE YOU PREGNANT YES_____ NO _____

WHAT MEDICATIONS OR DRUGS ARE YOU TAKING? (Including birth control pills)_____

_____ DATE OF LAST SPINAL X-RAY:_____

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE? YES _____ NO _____ DOCTOR'S NAME:_____

ADDITIONAL INFORMATION YOU WOULD LIKE TO TELL US:_____

_____

HAVE YOU EVER SUFFERED FROM: **(#1 Constant) (#2 Often) (#3 Seldom)**

☐ **Allergies**	☐ **Excessive menstrual flow**	☐ **Deafness**	☐ **Sinus Infections**
☐ **Dizziness**	☐ **Hot Flashes**	☐ **Ear Noises**	☐ **High Blood Pressure**
☐ **Fatigue**	☐ **Irregular Cycle**	☐ **Thyroid**	☐ **Low Blood Pressure**
☐ **Headaches**	☐ **Drug Addiction**	☐ **Eye Pain**	☐ **Pain Over Heart**
☐ **Loss of sleep**	☐ **Depression**	☐ **Failing Vision**	☐ **Poor Circulation**
☐ **Ulcers**	☐ **Numbness**	☐ **Venereal Disease**	☐ **Rapid Heart Beat**
☐ **Nervousness**	☐ **Polio**	☐ **Bed Wetting**	☐ **Slow Heart Beat**
☐ **Arthritis**	☐ **Sciatica**	☐ **Lumps in Breast**	☐ **Anemia**
☐ **Bursitis**	☐ **Spinal Curvature**	☐ **Alcoholism**	☐ **Stroke**
☐ **Foot Trouble**	☐ **Swollen Joints**	☐ **Nausea**	☐ **Chest Pain**
☐ **Low Back Pain**	☐ **Diarrhea**	☐ **Tuberculosis**	☐ **Difficult Breathing**
☐ **Frequent Urination**	☐ **Difficult Digestion**	☐ **Bruise Easily**	☐ **Pleurisy**
☐ **Kidney Infections**	☐ **Hemorrhoids**	☐ **Hay Fever**	☐ **Spitting**
☐ **Kidney Stones**	☐ **Immune Deficiency Syndrome**	☐ **Nosebleeds**	☐ **Swelling of Ankles**
☐ **Prostate Trouble**		☐ **Asthma**	☐ **Cancer**
☐ **Cramps or Backache**		☐ **Colds**	☐ **Diabetes**

CHECK OFF

HABITS	HEAVY	MODERATE	LIGHT	NONE		HABITS	HEAVY	MODERATE	LIGHT	NONE
Dairy						**Appetite**				
Alcohol						**Sodas**				
Drugs						**Tea**				
Exercise						**Sweets**				
Coffee						**Water**				
Sleep						**Tobacco**				

BILLING INFORMATION

IS THIS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF YOUR EMPLOYMENT? YES ____ NO ____

DATE SYMPTOM APPEARED OR ACCIDENT HAPPENED:_____ _____SAME OR SIMILAR CONDITION? YES ____ NO ____

HAVE YOU LOST ANY DAYS FROM WORK? YES ___ NO ____

NAME OF HEALTH INSURANCE:_____ PHONE#:_____

PAYMENT IS EXPECTED IN FULL AT TIME OF VISIT:

NAME OF PERSON RESPONSIBLE FOR PAYMENT:_____

I clearly understand agree ***that all services rendered me are charged directly to me and that I am personally responsible for payment.***

PATIENTS SIGNATURE:_____ DATE:_____

PARENT OR GUARDIAN AUTHORIZING CARE:_____ DATE:_____

Information taken by:_____ Date:_____