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