Kirstin Ebaugh, DC * 1907 Garden Ave., #102 * Eugene, OR 97403 * (541) 321-5700 * www.wholehealthchiro.net

PERSONAL INFORMATION **DATE: ________________**

Name ____________________________________ Phone (   ) ________________ Cell (   )___________________

Email Address: ___________________________ How often do you check email?________ Social Security #_______________

Address ______________________________ City ______________________ State ________ Zip code _______________

Age _____ Birthdate ___________ Gender: M / F Height _______ Weight _______ No. Children _________

Marital Status: * Single * Married * Widowed * Separated * Divorced *Partnered * Student: * Yes * No

Occupation __________________ Employer ___________________________ Work Phone (___)________________

Employer Address _____________________________________ City ________________ State ____ Zip code __________

Emergency Contact _______________________ Phone (___)______________ Relationship _______________________

Primary Care Physician (PCP) _______________________________________ Phone (   )______________________

Date of Last Physical Exam _______________ How did you of hear me? Insurance Company, My website, other:__________

PERSONAL HEALTH HISTORY

Please mark *'X'* for current conditions and *'P'* for past conditions you have or have had

GENERAL SYMPTOMS/ILLNESSES

__ Seizures
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing
__ Diabetes
__Cancer: ______________________

MUSCLES & JOINTS

__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains: what?_______
__ Broken Bones: what?_______

CARDIO-VASCULAR

__ High Blood Pressure
__ Heart Attack
__ Chest pain
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart rate
__ Slow Heart rate
__ Stroke
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT

__ Earache
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis
__ Hypothyroidism
__ Hyperthyroidism

GASTRO-INTESTINAL

__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY

__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY

__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES

__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Allergy ___________

FOR WOMEN ONLY

__ Birth Control _________
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time: Yes No

Please list all **allergies** including allergies to medications ____

List all **medications** you are presently taking (***including vitamins & supplements***) ____

____

Indicate all **surgeries** you have had: NONE Appendix Tonsils Hernia Gallbladder Uterus Tubes Tied Heart Oral Back/neck Knee Shoulder Hip List other surgeries:

____

List other **hospitalizations**____

Have you ever been in a motor vehicle accident? * Yes * No. If yes, when? _____________. Where you hurt? * Yes * No.

Please briefly describe your injuries, if applicable: ____

Please describe any other serious injuries you have had. Provide a year and a description of what body part was hurt, and what care, if any, you received: ____

____

Do you have a Living Will or Advance Directive? □ Yes □ No

In an emergency would you want CPR? □ Yes □ No

In an emergency would you want life support? □ Yes □ No

SOCIAL HISTORY

Do you drink alcoholic beverages? Yes No If yes, what? _______________________ How much per week?_________

Do you smoke? Yes No If so, packs per day: ____

Do you consume caffeine? Yes No If yes, how much per day:_____________________

Do you exercise? Yes No If yes, what type of exercise? ___________________________ How often: ____________________

What are your hobbies?____

How many hours each day (at home or at your job) are you: lifting ____ sitting ____ bending ____ at a computer _____

<u>Pediatric Records</u>: (<u>under 17</u>) Are your immunizations up to date? □ Yes □ No (Please provide complete immunization record)

FAMILY HEALTH HISTORY __

Mark boxes for <u>family members</u> who have/had any of the following (***F***=*father;* ***M***=*mother;* ***S***=*sister;* ***B***=*brother;* ***O***=*other*):

___Cancer ___Diabetes ___Heart Disease ___High Blood Pressure ___Stroke ___Epilepsy

___Chronic Headaches ___Lupus ___Lung Problem ___Rheumatoid Arthritis ___Alcoholism

Other ____

I certify that all the above personal health information is complete and accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient (or Guardian) Signature ____ Date ___________________