

Family Holistic Health Care of Fairfield

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PATIENT INFORMATION

Name: _____ Age _____ Date of Birth: _____ Date _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone (Home): _____ Sex: F M Marital Status: S M D W # Children: _____
 Occupation: _____ Employer: _____ Telephone (Work) _____ Extension: _____
 Social Security Number: _____ Insured's Date of Birth: _____
 Insured's Name: _____ Phone: _____ Spouse's Occupation: _____
 Insured's Spouse's Telephone (Work): _____
 Spouse's Employer: _____ Past Chiropractic Care: Yes No When? _____
 Referred by: _____ Results: _____
 Doctor's Name: _____
 Insurance Company: _____ Spouse's Social Security Number: _____

Chief Complaint: 1. _____ Duration (How long): _____ Previous Episodes _____
 List Current 2. _____ Duration (How long): _____ Previous Episodes _____
 Problems 3. _____ Duration (How long): _____ Previous Episodes _____

Is the condition getting progressively worse? Yes No Constant Comes & goes

What activities aggravate your condition? _____

Are your present problems due to an injury? No Yes On Job Auto Accident Personal Injury Other: _____

Drugs you now take: Nerve pills Painkillers Muscle relaxers Blood pressure pills Insulin
 Birth control pills Vitamin supplements Others _____

Do you wear: Heel lifts orthotics Arch supports Any other conditions you suffer from at this time? _____

Name and address of primary care physician _____

Please mark area & type of pain on the drawings using the codes listed below

Please mark the intensity of your pain today

1= NO PAIN

10= MOST INTENSE EVER FELT

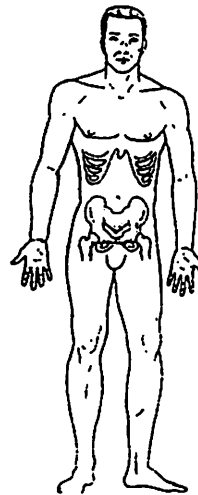
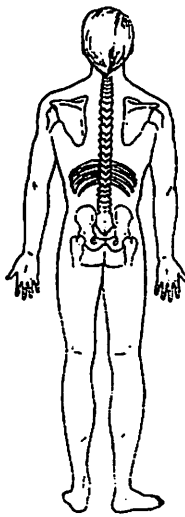
Example 1-2-3-4-5-6-7-8-9-10-

1. -1-2-3-4-5-6-7-8-9-10-

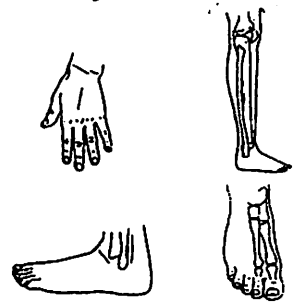
2. -1-2-3-4-5-6-7-8-9-10-

3. -1-2-3-4-5-6-7-8-9-10-

DOCTOR USE ONLY



N = Numbness P = Pain
 T = Tingling A = Ache
 S = Soreness ST = Stiffness



HABITS

EXERCISE

FAMILY HISTORY

<input type="checkbox"/> Smoking	Packs/Day: _____	<input type="checkbox"/> None		Diabetes		Heart		Cancer		Back
<input type="checkbox"/> Drinking	Alcohol: _____	<input type="checkbox"/> Moderate	Mother	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Coffee	Cups/Day: _____	<input type="checkbox"/> Daily	Father	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Water	Cups/Day: _____	Type: _____	Siblings, # of _____	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

PAST HEALTH HISTORY

Please be as complete as possible. All information is strictly confidential.

List surgical operations and years _____

Have you ever had a(n): Auto Accident Sports Injury Household Accident Work Injury Personal Injury

Have you ever been hospitalized? _____ Have you broken any bones? _____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- Appendicitis
- Pneumonia
- Rheumatic Fever
- Polio
- Tuberculosis
- Whooping Cough
- Anemia
- Measles
- Mumps
- Chicken Pox
- Diabetes
- Cancer
- Heart Disease
- Goiter
- Influenza
- Pleurisy
- Alcoholism
- Venereal Disease
- Arthritis
- Epilepsy
- Mental Disorder
- Lumbago
- Eczema
- HIV Positive

Please check the correct box for each choice below. Check at least one box for each sign or symptom listed.

N = Never O = Occasional F = Frequent

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <u>GENERAL SYMPTOMS</u>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <u>GASTRO-INTESTINAL</u>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <u>EYE/EAR/NOSE/THROAT</u>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <u>RESPIRATORY</u>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy (what) _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belching or Gas	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest Pain
_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic Cough
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear Discharge	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting Blood
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear Noises	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting Phlegm
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gall Bladder Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged Thyroid	<u>GENITO-URINARY</u>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids (piles)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent Colds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed Wetting
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay Fever	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in Urine
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarseness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent Urination
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of Weight	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Inability to Control Urine
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over Stomach	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney Infection
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Night Sweats	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Appetite	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Vision	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Urination
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness or pain in arms/legs/hands	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Digestion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinusitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate Trouble
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore Throats	<u>FOR WOMEN ONLY</u>
<u>MUSCLES & JOINTS</u>	<u>CARDIO-VASCULAR</u>	<u>SKIN OR ALLERGIES</u>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps or Backache
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Backache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive Flow
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruising Easily	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot Flashes
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain between Shoulders	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Tail Bone	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Circulation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eczema	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Miscarraige
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stiff Neck	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or Allergies	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Periods
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal Curvature	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen Joints	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling Ankles	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sensitive Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant at this time?
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin Eruptions	Last Pap _____ By Whom _____

I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Douglas J. Koch, D.C. will prepare any necessary report and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Douglas J. Koch, D.C. will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed.

Patient's Signature: _____ Date _____

Guardian or Spouse's Signature: _____