Dr. Pierre Rousse, LLC **Patient History and Initial Health Status**

PERSONAL HISTORY

Name: ______________________ Address: ______________________

City: ______________________ State: ______________ Zip Code: __________

Home Phone: ______________________ Birth Date: ______________ Sex: □ M □ F

Cell Phone: ______________________ Email Address: ______________________

Social Security #: ______________________ Driver's License Number: ______________________

Employer: ______________________ Type of Work: ______________________

Business Phone: ______________________

Marital Status: ______________________ Name of Spouse:______________________

Spouse Employer:______________________ Type of Work: ______________________

Business Phone: ______________________

How were you referred to our office?______________________

Name and number of Emergency Contact: ______________________Relationship:__________

Who is responsible for your bill? You □ Spouse □ Personal Health Insurance □ Auto Insurance □ Medicare □

Health Insurance Company:______________________ Insured's Name:______________ Birthdate:__________

If we need to contact you, do you prefer to be contacted via □ home phone □ cell phone □ business phone □ email

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CURRENT HEALTH CONDITION

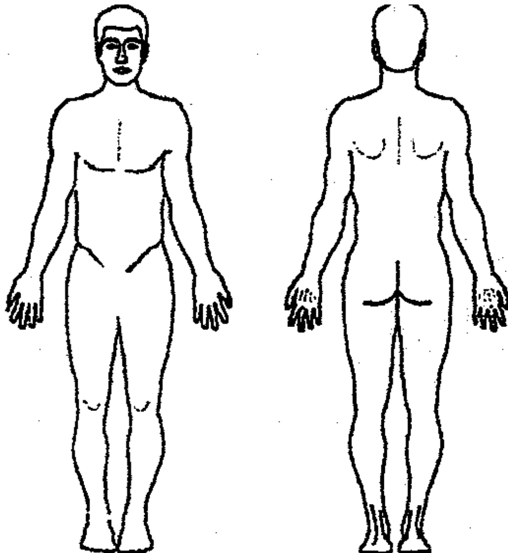
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

□ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □ Other ______________________

Is this condition □ Work Related □ Accident Related □ N/A

Date problem began:______________________ How problem began:______________________

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS AND INDICATE YOUR PAIN LEVEL TODAY ON THE SCALE FROM 0 TO 10



Current complain (how you feel today);

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?

(Intermittent) ☐ 0 – 25% ☐ 26 – 50 % ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, chores?)

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ NO ☐ YES

Date(s) taken:______________________________ What areas were taken?______________________________

Primary Care Physician Name:____________________ Phone:____________________

LIST ALL CURRENT MEDICATIONS (prescriptions & OTC):____

LIST ALL SURGERIES AND DATES:____

LIST ALL CURRENT VITAMIN /DIETARY SUPPLEMENTS:____

Please check all of the following that apply to you:

- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke (date)___________
- ☐ Corticosteroid Use (cortisone, prednisone, etc.)
- ☐ Taking Birth Control Pills
- ☐ Dizziness / Fainting
- ☐ Numbness in Groin / Buttocks
- ☐ Cancer / Tumor (explain)______________________
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Currently Pregnant, # weeks _______
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Marked Morning Pain / Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Visual Disturbances
- ☐ Epilepsy / Seizures
- ☐ Osteoporosis
- ☐ Other Health Problems (explain)______________________

Family History ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems / Stroke ☐ Rheumatoid Arthritis ☐ Back Pain

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature:______________________________ Date:____________________

If patient is a minor signature of parent or legal guardian is required:

Parent/Guardian :______________________________ Date:____________________