BRUCE MIRON, D.C.

PATIENT HISTORY

Date _____

Name _____ Phone (H) _____ (W) _____

Address _____ City _____ State _____ Zip _____

Age ___ Date of Birth _____ Height _____ Weight _____ Phone (C) _____

Occupation _____ Employer name & address _____

Marital Status _____ Name of Spouse _____ No. of children _____

Who is responsible for your bill? ( ) Self ( ) Spouse ( ) Health Insurance - Submit card with paperwork

( ) Auto Insurance ( ) Workmen's Comp. ( ) Other _____

Name of Policy Holder _____ Soc. Sec. No. _____

Relationship to you _____ Date of Birth _____

Name of nearest relative not living with you _____

Address _____

Phone (H) _____ (W) _____ Relationship _____

Was this injury related to: ( ) Work Accident ( ) Auto Accident

When was the last time you saw a chiropractor? _____ Dr. _____

In the spaces provided, please indicate which conditions apply to you using (**O**) for **past conditions** or (**X**) for **present conditions**:

_____ Fractured bones (Where?)
_____

_____ Auto accidents
(a) _____ 0-1 year ago
(b) _____ 1-5 years ago
(c) _____ More than 5 yrs. ago

_____ Other accidents/falls
_____ Knocked unconscious
_____ Back curvature
_____ Mental or emotional disorders
_____ Arthritis
_____ Diabetes
_____ Swollen or painful joints
_____ Convulsions/epilepsy
_____ Skin problems
_____ Itching
_____ Bruise easily
_____ Cancer
_____ Frequent colds/flus

_____ Nervous
_____ Tension
_____ Depressed
_____ Irritable
_____ Anemia
_____ Excess sweating
_____ Tremors
_____ Light bothers eyes
_____ Allergy
_____ Sinus problems
_____ Lightheaded upon arising
_____ Under stress
_____ Crave sweets or salt
_____ Eating disorders

_____ Trouble sleeping
_____ Trouble concentrating
_____ Loss of memory
_____ Learning disability
_____ Mistake sidedness (R from L)

_____ Dyslexia
_____ Mood changes
_____ Lose temper easily

Please circle all choices that apply:

_____ Headache
_____ Neck pain or stiffness L R
_____ Numbness, tingling, pain in arms, hands, fingers L R
_____ Jaw pain or click (TMJ) L R
_____ Head seems too heavy
_____ Head & shoulders feel tired
_____ Difficulty or pain in excessive: standing, walking, sitting, riding, bending, lifting, twisting, household duties
_____ Shoulder pain L R
_____ Dizziness
_____ Ringing in ears L R
_____ Hearing loss L R
_____ Fainting
_____ Loss of balance
_____ Blurred or double vision L R
_____ Upper Back pain or stiffness L R
_____ Mid Back pain or stiffness L R
_____ Low Back pain or stiffness L R
_____ Numbness, tingling or pain in buttocks, thighs, legs, feet, toes L R
_____ Pain with cough, sneeze, or strain at stools
_____ Back pain due to sexual activity
_____ Hip pain L R
_____ Knee pain or stiffness L R
_____ Foot trouble L R

_____ Chest pain
_____ Asthma
_____ Lung problems

_____ Difficulty breathing
_____ Wheezing
_____ Heart problems
_____ Stroke
_____ High or low blood pressure
_____ Varicose veins
_____ Liver trouble
_____ Gall bladder trouble

_____ Digestive problems
_____ Excessive gas
_____ Belching/bloating after meals
_____ Heartburn
_____ Ulcers
_____ Diarrhea/constipation
_____ Colon trouble
_____ Hemorrhoids
_____ Prostate problems
_____ Impotence

_____ Kidney trouble
_____ Kidney stones
_____ Frequent urination
_____ Painful urination
_____ Discharge
_____ Menstrual problems/PMS
_____ Menopausal problems
_____ Breast lumps, soreness, discharge
_____ Bedwetting
_____ Ear infections
_____ Hepatitis
_____ Venereal disease
_____ AIDS/ARC/HIV positive
_____ Pregnant (now)

I am (Right) (Left) handed

_____ _____