CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Myshka Chiropractic
Dr. Susan J. Myshka
2817 South Caraway Rd
Jonesboro, Arkansas 72401-7305
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www.myshkachiro.com
myshka2817@aol.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ◯ No ◯ Yes When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Your Last Name | Your Social Security Number | Birth Date (MM/DD/YYYY) | Age

Your First Name | Your Middle Name (or Initial) | Gender ◯ Male ◯ Female | Race

Address | Marital Status ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated | Ethnicity

City | State/Province | ZIP/Postal Code | Preferred Language

Home Phone | Cell Phone | Spouse's Name

Email Address | Child's Name and Age

Emergency Contact | Emergency Contact's Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer | Work Phone

Address

May we contact you at work? ◯ Yes ◯ No

City | State/Province | ZIP/Postal Code

Preferred method of contact? ◯ Home Phone ◯ Cell Phone ◯ Work Phone ◯ Email

Primary Care Provider's Name

Insurance Carrier | Policy Number

Insured's Last Name | Birth Date (MM/DD/YYYY) | Who carries this policy? ◯ Self ◯ Spouse ◯ Parent

Insured's First Name | Insured's Middle Name (or Initial)

Insured's Employer

Address

City | State/Province | ZIP/Postal Code | Employer's Phone

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1. The symptom(s) that have prompted me to seek care today include: ____________________

2. And are the result of (darken circle): ◯ An accident or injury
◯ Work ◯ Auto ◯ Other ____________
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other ____________

3. Onset (When did you first notice your current symptoms?) ____________

4. Intensity (How extreme are your current symptoms?)

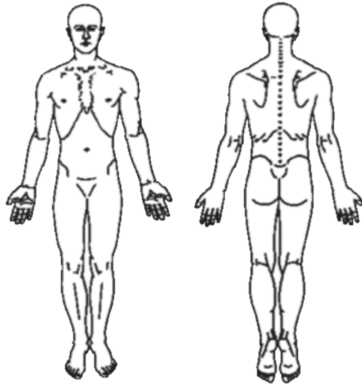
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
◯ Constant ◯ Comes and goes. How Often? ____________

6. Quality of symptoms (What does it feel like?)

- ◯ Numbness
- ◯ Tingling
- ◯ Stiffness
- ◯ Dull
- ◯ Aching
- ◯ Cramps
- ◯ Nagging
- ◯ Sharp
- ◯ Burning
- ◯ Shooting
- ◯ Throbbing
- ◯ Stabbing
- ◯ Other ____________

7. Location (Where does it hurt?) Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.) ____________

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? ____________
What tends to lessen the problem? ____________

10. Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other ____________
◯ Physical therapy ◯ Massage ____________

11. What else should Dr. Myshka know about your current condition? ____________

12. How does your current condition interfere with your:

Work or career: ____________
Recreational activities: ____________
Household responsibilities: ____________
Personal relationships: ____________

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal (Had / Have)
◯ ◯ Osteoporosis ◯ ◯ Arthritis ◯ ◯ Scoliosis ◯ ◯ Neck pain ◯ ◯ Back problems ◯ ◯ Hip disorders — NONE ◯
◯ ◯ Knee injuries ◯ ◯ Foot/ankle pain ◯ ◯ Shoulder problems ◯ ◯ Elbow/wrist pain ◯ ◯ TMJ issues ◯ ◯ Poor posture — Initials ____

b. Neurological (Had / Have)
◯ ◯ Anxiety ◯ ◯ Depression ◯ ◯ Headache ◯ ◯ Dizziness ◯ ◯ Pins and needles ◯ ◯ Numbness — NONE ◯ Initials ____

c. Cardiovascular (Had / Have)
◯ ◯ High blood pressure ◯ ◯ Low blood pressure ◯ ◯ High cholesterol ◯ ◯ Poor circulation ◯ ◯ Angina ◯ ◯ Excessive bruising — NONE ◯ Initials ____

d. Respiratory (Had / Have)
◯ ◯ Asthma ◯ ◯ Apnea ◯ ◯ Emphysema ◯ ◯ Hay fever ◯ ◯ Shortness of breath ◯ ◯ Pneumonia — NONE ◯ Initials ____

e. Digestive (Had / Have)
◯ ◯ Anorexia/bulimia ◯ ◯ Ulcer ◯ ◯ Food sensitivities ◯ ◯ Heartburn ◯ ◯ Constipation ◯ ◯ Diarrhea — NONE ◯ Initials ____

f. Sensory (Had / Have)
◯ ◯ Blurred vision ◯ ◯ Ringing in ears ◯ ◯ Hearing loss ◯ ◯ Chronic ear infection ◯ ◯ Loss of smell ◯ ◯ Loss of taste — NONE ◯ Initials ____

g. Skin (Had / Have)
◯ ◯ Skin cancer ◯ ◯ Psoriasis ◯ ◯ Eczema ◯ ◯ Acne ◯ ◯ Hair loss ◯ ◯ Rash — NONE ◯ Initials ____

Patient name ____________

Patient Number (office use only) ____________

Consultation Notes

Doctor's Initials ____________

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h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯ Initials
◯	◯	Thyroid issues	◯	◯	Immune disorders	◯	◯	Hypoglycemia	◯	◯	Frequent infection	◯	◯	Swollen glands	◯	◯	Low energy	

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯ Initials
◯	◯	Kidney stones	◯	◯	Infertility	◯	◯	Bedwetting	◯	◯	Prostate issues	◯	◯	Erectile dysfunction	◯	◯	PMS symptoms	

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯ Initials
◯	◯	Fainting	◯	◯	Low libido	◯	◯	Poor appetite	◯	◯	Fatigue	◯	◯	Sudden weight gain/loss (circle one)	◯	◯	Weakness	

Patient name

Patient Number
(office use only)

◯ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have	Illness
◯	◯	AIDS
◯	◯	Alcoholism
◯	◯	Allergies
◯	◯	Arteriosclerosis
◯	◯	Cancer
◯	◯	Chicken pox
◯	◯	Diabetes
◯	◯	Epilepsy
◯	◯	Glaucoma
◯	◯	Goiter
◯	◯	Gout
◯	◯	Heart disease
◯	◯	Hepatitis
◯	◯	HIV Positive
◯	◯	Malaria
◯	◯	Measles
◯	◯	Multiple Sclerosis
◯	◯	Mumps
◯	◯	Polio
◯	◯	Rheumatic fever
◯	◯	Scarlet fever
◯	◯	Sexually transmitted disease
◯	◯	Stroke
◯	◯	Tuberculosis
◯	◯	Typhoid fever
◯	◯	Ulcer
◯	◯	Other: ________

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ◯ Appendix removal
- ◯ Bypass surgery
- ◯ Cancer
- ◯ Cosmetic surgery
- ◯ Elective surgery: ________
- ◯ Eye surgery
- ◯ Hysterectomy
- ◯ Pacemaker
- ◯ Spine ________
- ◯ Tonsillectomy
- ◯ Vasectomy
- ◯ Other: ________

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	Treatment
◯	◯	Acupuncture
◯	◯	Antibiotics
◯	◯	Birth control pills
◯	◯	Blood transfusions
◯	◯	Chemotherapy
◯	◯	Chiropractic care
◯	◯	Dialysis
◯	◯	Herbs
◯	◯	Homeopathy
◯	◯	Hormone replacement
◯	◯	Inhaler
◯	◯	Massage therapy
◯	◯	Physical therapy
◯	◯	Nutritional supplements: List: ________
◯	◯	Medications (prescription and over-the-counter): ________

17. Injuries

Have you ever...

- ◯ Had a fractured or broken bone
- ◯ Had a spine or nerve disorder
- ◯ Been knocked unconscious
- ◯ Been injured in an accident
- ◯ Used a crutch or other support
- ◯ Used neck or back bracing
- ◯ Received a tattoo
- ◯ Had a body piercing

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Dr. Myshka about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health: Good	State of health: Poor	Illnesses	Age at death	Cause of death: Natural	Cause of death: Illness
Mother		◯	◯			◯	◯
Father		◯	◯			◯	◯
Sister 1		◯	◯			◯	◯
Sister 2		◯	◯			◯	◯
Brother 1		◯	◯			◯	◯
Brother 2		◯	◯			◯	◯
________		◯	◯			◯	◯

19. Are there any other hereditary health issues that you know about? ________

20. Social History

Tell Dr. Myshka about your health habits and stress levels.

SOCIAL

Alcohol use	◯ Daily	◯ Weekly	How much? ________
Coffee use	◯ Daily	◯ Weekly	How much? ________
Tobacco use	◯ Daily	◯ Weekly	How much? ________
Exercising	◯ Daily	◯ Weekly	How much? ________
Pain relievers	◯ Daily	◯ Weekly	How much? ________
Soft drinks	◯ Daily	◯ Weekly	How much? ________
Water intake	◯ Daily	◯ Weekly	How much? ________

Hobbies: ________

Prayer or meditation?	◯ Yes	◯ No
Job pressure/stress?	◯ Yes	◯ No
Financial peace?	◯ Yes	◯ No
Vaccinated?	◯ Yes	◯ No
Mercury fillings?	◯ Yes	◯ No
Recreational drugs?	◯ Yes	◯ No

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