## **CONFIDENTIAL HEALTH INFORMATION**

Tallant Chiropractic, LLC 3949 S. Hwy 97 Sand Springs, OK 74063 918-245-2790 (Fax) 918-245-8436

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.

Today's Date (MM/DD/YYYY)	-	you consulted a chiropractor befor  O Yes When?	e?	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	Ethnicity
City	State/Province	ZIP/Postal Code	○ Widowed ○ Separated	Preferred Language
Home Phone	Cell Phone		Spouse's Name	
Email Address			Child's Name and Age	
Emergency Contact	Emergency Con	tact'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	CONFIDENTIAL
City	State/Province	ZIP/Postal Code	Preferred method of contac	t? <u> </u>
Primary Care Provider's Name			○ Work Phone ○ Email	m Z
Insurance Carrier		Policy Number		<u></u>
Insured's Last Name		Birth Date (MM/DD/YYYY)	Who carries this policy?  Self Spouse Parer	
Insured's First Name	Insured's Middl	le Name (or Initial)		<u> </u>
Insured's Employer				HEALTH INFORMATION
Address				\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
City	State/Province	ZIP/Postal Code	Employer's Phone	<u> </u>

1. The symptom(s) that	nave pror	nptea me to	seei	k care today include:								
												Patient name
2. And are the result of	(darken ci	() () A w	○ W vorser	ent or injury /ork	_	er					_	Patient Number (office use only)
<b>3. Onset</b> (When did you fir your current symptoms?)		current symp	ptoms ——		0	5. Duration and Ti	_			ow often do you feel	it?)	
6. Quality of symptoms it feel like?)  Numbness	(What does	Circle the ar "0" for curren	ea(s) t cond	on the illustration.		8. Radiation (Does pain radiate, shoot or			our bo	ody? To what areas d	oes the	
<ul><li>○ Tingling</li><li>○ Stiffness</li><li>○ Dull</li><li>○ Aching</li><li>○ Cramps</li><li>○ Negation</li></ul>			)			9. Aggravating or time of day, movemer What tends to v the problem? What tends to I the problem?	nts, c vorse	ertain activities, etc.) en		ses it better or worse,	such as	
<ul><li>Nagging</li><li>Sharp</li><li>Burning</li><li>Shooting</li><li>Throbbing</li><li>Stabbing</li><li>Other</li></ul>			A PO			10. Prior interven Prescription me Over-the-count Homeopathic re Physical therap	edicat er dru emed	ion Surgery ugs Acupunctu	re	relieve the symptom loe Heat Other		S
11. What else should Ta	ıllant Chir	opractic, LL	C kn	ow about your currer	it co	ondition?						Consultation Notes
12. How does your curre	ent condit	ion interfere	with	ı your:							d	
Work or career:												
Recreational activitie  Household responsib												
Personal relationship	_											
13. Review of Systems Chiropractic care focuses or Had or currently Have and	n the integri		/ous s	system, which controls a	nd r	egulates your entire b	ody.	Please darken the c	ircle t	peside any condition	that you've	
a. Musculoskeletal Had Have O Osteoporosis O Knee injuries	Had Have		0	Have Scoliosis Shoulder problems	0	Have  Neck pain Elbow/wrist pai	0	Have O Back problems O TMJ issues	0	Have     Hip disorders     Poor posture	NONE O	
b. Neurological Had Have Anxiety	Had Have	epression	Had		Had (	Have O Dizziness	Had	Have O Pins and needles	Had	Have Numbness	NONE O	
O O High blood pressure	Had Have	ow blood ressure		Have High cholesterol		Have O Poor circulation		Have Angina	Had	Have © Excessive bruising	NONE O	
O O Asthma	Had Have	pnea	_	Have O Emphysema	_	Have Hay fever	Had	Have Shortness of breath		Have O Pneumonia	NONE O	
O Anorexia/bulimia	Had Have	lcer	Had	_		Have Heartburn	Had	Have		Have O Diarrhea	NONE O	Doctor's Initials
O O Blurred vision	Had Have	inging in ears		Have O Hearing loss	Had (	Have O Chronic ear infection		Have O Loss of smell		Have O Loss of taste	NONE O	Tallant Chiropractic, LLC
g. Skin Had Have O O Skin cancer	Had Have	soriasis		Have © Eczema		Have Acne		Have O Hair loss		Have O Rash	NONE (	PAGI

h. E Had	enitourinary	Had Have	mmune disorders		⊃ Hypoglycemia	0	Have     Frequent infection	0	Have Swollen gland	ls O	0,7	NONE O	Patient name
Had	d Have ○ Kidney stor	Had Have		Had H	ave Dedwetting	Had	O Prostate issues		Have  C Erectile dysfunction		O PMS symptoms	NONE O	Patient Number (office use only)
Had	onstitutional  Have  Fainting	Had Have	Low libido	Had H	ave Poor appetite		Have Fatigue	Had	Have	nt O	Have Weakness	NONE O	All other systems negative
	Personal, Fam			dents,	injuries, illnesses and	trea	tments. Please comp	ete e	ach section fully.				
PERSONAL	O All O Ca O Ch O Dia O Ep O Ga O Ga O He O He O He O He O Ma O Ma O Ma O Ma O Rh O Sc S	DS coholism lergies teriosclerosis uncer nicken pox abetes iilepsy aucoma	Had   Have   Tu   Tu   Ty   Tu   Tu   Tu   Tu   Tu	bercul phoid cer her: c to an s please  B. Inju H	osis iever  y medications?	- - - - - - isorc	Eye surgery Hysterectomy Pacemaker Spine Tonsillectomy Vasectomy Other:  one Used a deler Used ne	ed hoval ry gery gery: / / crutcl	n or other support	Chec Past Past C C C C C C C C C C C C C C C C C C C	Acupuncto Antibiotics Birth control Blood trar Chemothe Chiroprac Dialysis Herbs Homeopal Hormone Massage I Physical ti	ently.  ure s rol pills insfusions erapy tic care  thy replacement therapy herapy is ver-the-counter,	Consultation Notes
10.5		roke		) Bi	een injured in an acci	aent	O Had a bi	oay p	nercing	_			
					LC about the health o	f you	•	emb	ers.				
FAMILY	Mother Father Sister 1 Sister 2 Brother 1 Brother 2	Age (IT IIV		Poor			Illnesses			_		al Illness	
20. /	Are there any o	ther heredita	ry health issu	es tha	t you know about?								
	_												
	<b>Social History</b> allant Chiropraction	c, LLC about yo	ur health habits	and st	ress levels.								
	Alcohol use	O Daily	-	w mucl					Prayer or med			○No	
	Coffee use	O Daily	-	w mucl					Job pressure,			○No	
긡	Tobacco use	O Daily O	-	w mucl					Financial pea	ce?		○No	Doctor's Initials
SOCIAL	Exercising Pain relievers	O Daily O Daily		v mucl v mucl					Vaccinated?  Mercury fillin	us?		○No ○No	Tallant Chiropractic, LLC
SC	Soft drinks	-			1? 1?				Recreational (			○ No	
	Water intake				1?				noor outforidi (	uruys	. 0103	.,,,	PAGE

Hobbies: \_

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Rising out of chair    Household choices   Hou	Patient Number (office use solid)  Watching — Heaching coethead — Heaching proteinsed — Office use solid)  Berding over — Dressing myself — Office use solid)  Ending over — Dressing myself — Office use solid)  Ending row — Showing no tathing — Office use solid in the solid patient of car — Shiping asking — Office use solid in the solid patient of car — Shiping asking — Office use solid in the solid patient of car — Shiping asking — Office use solid in the solid patient of car — Shiping asking — Office use solid in the solid patient of car — Shiping asking — Office use solid in the solid patient of car — Shiping asking — Office use solid in the solid patient of car — Shiping asking — Office use solid in the solid patient of car — Shiping asking — Office use solid in the solid patient of car — Shiping asking — Office use solid patient of car — Shiping asking — Office use solid patient of car — Shiping asking — Office use solid patient of car — Shiping asking — Office use solid patient of car — Shiping asking — Office use solid patient of car — Shiping asking — Office use solid patient of car — Shiping asking — Office use solid patient of car — Shiping asking — Office use solid patient of car — Shiping asking — Office use solid patient of car — Shiping asking — Office use solid patient of car — Shiping asking — Office use solid patient of car — Of	onning -		No Effect	Mild Effect	Moderate Effect	Severe Effect	Grocery shopping ————	No Effect	Mild Effect	Moderate Effect	Severe Effect	Patient name
Lifting objects   Lifting ob	Starding			_				, 11 5	Ŭ				Patient Number
Walking	Walking			_	_				•	_			
Lying down Showering or bathing Dressing mynee! Dressing mynee	Lying down	0		_	_	_			_	_	_		
Climbing stairs  Love life  Getting in/lout of car	Desiring year   Dressing mysel   Dressing mysel   Dressing mysel   Dressing mysel   Dressing accompleter   Dressing accomplete   Dressing accomple			_	_			ū	•	_	•		
Using a computer   Getting fivolat of car   Getting fivolation   Getting fivo	Climbing stairs			_	_				_	_			
Using a computer	Using a computer	_		_	_	_			_	_			
Getting in/out of car	Gatting in/out of car	_		_	_	_			_	_	_		
Driving a car Concentrating Percising Percision Percisio	Driving a car Concentrating County Shoulder Caring for family Pard work Shoulder Caring for family Pard work Shoulder Sh	-		_	_	_		0 1	•	_			
Looking over shoulder	Looking over shoulder	_		_	_	_			_	_			
Caring for family	Caring for family    Yard work	•		_	_	_		<u> </u>	_	_	_		
3. What is the major stressor in your life?	3. What is the major stressor in your life?			_	_	_		-	_	_			
Describe your typical eating habits: Skip breakfast Two meals a day Snacking between meals  Describe your typical eating habits: Skip breakfast Two meals a day Snacking between meals  Describe your typical eating habits: Skip breakfast Two meals a day Snacking between meals  Describe your typical eating habits: Skip breakfast Two meals a day Snacking between meals  Describe your typical eating habits: Skip breakfast Two meals a day Snacking between meals  Describe your typical eating habits: Skip breakfast Two meals a day Snacking between meals  Describe your typical eating habits: Skip breakfast Two meals a day Snacking between meals  Describe your typical eating habits: Skip breakfast Two meals a day Snacking between meals  Describe your typical eating habits: Skip breakfast Two meals a day Snacking between meals  Describe your typical eating habits: Skip breakfast Two meals a day Snacking between meals  Describe your typical eating habits: Skip breakfast Two meals a day Snacking between meals  Describe your typical eating habits: Skip breakfast Two meals a day Snacking between meals  Describe your typical eating habits: Skip breakfast Two meals a day Snacking between meals  Describe your typical eating habits: Skip breakfast Two meals a day Snacking between meals  Describe your typical eating habits: Skip breakfast Two meals a day Snacking between meals  Describe your typical eating habits: Skip between the best between the ach salk where meals a day Snacking between meals  Describe your typical eating habits: Skip between the latting between the latting habits: Skip between the latting habits: In a day on a death the latting habits your agreement.  Describe your typical eating habits: Skip between the latting habits	Now had is the type and approximate age of your mattress and pillow?	Ü	,			O	O		<u> </u>				
Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals  What would be the most significant thing that you could do to improve your health?  In addition to the main reason for your visit today, what additional health goals do you have?  In addition to the main reason for your visit today, what additional health goals do you have?  I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.  I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.  I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):  I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.  I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.  To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the	Describe your typical eating habits:  Skip breakfast  Two meals a day  Three meals a day  Snacking between meals  What would be the most significant thing that you could do to improve your health?  In addition to the main reason for your visit today, what additional health goals do you have?  In addition to the main reason for your visit today, what additional health goals do you have?  I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.  I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.  I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):  I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.  I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.  To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.	. What is	s the major stressor	r in your lite?				24. How much sleep	do you average	e per nigh	t?	Hours	
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In addition to the main reason for your visit today, what additional health goals do you have?    Page   Pa	In addition to the main reason for your visit today, what additional health goals do you have?    Instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.  I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.  I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):    I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.  I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.  To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.    Doctor's Initials   Doct		o your typiour ouring		onip broan	1401 ( ) 111	o modio a daj	y O moo moano a day O on	laoking bothoon	mouro			
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