180 Health Solutions

PLEASE NOTE:

This file must be saved to your desktop before and after completing.

PATIENT INFORMATION

First Name_____ Middle Name_____ Last Name_____

DOB_____ Height_____ Weight_____ Sex _____ SSN_____

Marital Status_____ Spouse Name_____ Number of Children_____

Address_____ City_____ State _____ Zip_____

Home Phone _____ Cell Phone_____

Email_____ Emergency Contact _____

Emergency Relation_____ Emergency Phone _____

Employed? Yes No Employer Name_____ Occupation_____

REFERRAL INFORMATION

I was referred by_____

How did you hear about the clinic?

Family Friend Radio Community Event Provider Talk Social Media Other_____

Describe in your own words why you wanted to come for an appointment today:_____

_____

Complaints/Concerns

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
E.g. Headaches	*June 20*	*4 times per week*	*Mild / Moderate / Severe*
1.			
2.			
3.			
4.			
5.			
6.			
7.			

When was the last time you felt well? _____

How many Doctors have you seen for this condition?_____

What medications, supplements, therapies, or treatments did they prescribe or recommend for you? _____

_____

Has what you've done to date helped your condition? _____

What are 3-5 activities you can no longer do or are struggling to do because of this condition? Please be specific.

_____

_____

_____

_____

_____

Keeping in mind that problems that are not addressed tend to get worse with time, what is your honest vision of your life in the next few years if this problem continues to progress? _____

_____

What would be different or better without this problem? Please be specific. _____

_____

What is your biggest fear in regards to the progression of this condition? _____

_____

What would success mean to you in our office? _____

_____

Medications and Supplements

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs. Attached your own list if it is longer than the space given.

Medication Name	Dosage

Supplements: List all vitamins, minerals, and other nutritional supplements that you are currently taking.

Supplement Name	Dosage

Allergies

I am allergic to the following medications:

I am allergic to the following foods or supplements:

Please list your symptoms/reactions to the above medications and/or foods:

Type of Injury_____

Pain level on a scale of 1-10 (10 is excruciating pain) At its best? _____ At its worst? _____ Now?_____

How did it occur? Work Automobile Fall Other_____

Injury Date _____ Have you missed work related to this injury? Yes No

Unable to work from (dates) _____ to _____

Received other treatment for this? Yes No Where or by whom? _____

X-rays taken? Yes No Do you currently receive chiropractic care? Yes No

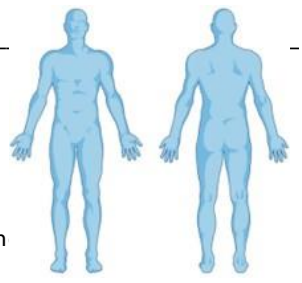
What clinic or chiropractor provides that care?_____

Please circle the character of your current pain (you may circle more than one)

Sharp Stabbing Dull Aching SSooreness

Numbness Shooting Tingling Weakness Throbbing

Put an X on the body th location of the injury or pain



How often are your symptoms present? Constant Frequent Occasional Intermittent

Since your problem began, is the pain? Increasing Decreasing No Change

What activities make symptoms **better**?

Sitting Standing Laying Down Movement/Exercise Sleep/Rest Other:_____

What activities make symptoms **worse**?

Sitting Standing Laying Down Movement/Exercise Sleep/Rest Other:_____

Health History

Please check if you have ever had any of the following:

Health Conditions	Last 60 Days	Ever	Never
Cramps			
Nosebleeds			
Hemorrhoids			
Frequent Neck Pain or Shoulders			
Asthma			
Shortness of Breath/Chest Pain			
Bronchitis			
Numbness/Pain in Arms/Legs/Hands			
Chronic Fatigue Syndrome			
Crohn's/ Irritable Bowel			
Lower Back Problems/Sciatica			
Emphysema			
Epilepsy, convulsions			
Gallstones			
Gout			
Heart attack/Angina/Heart failure			
Heart Surgery/Pacemaker			
Hepatitis			
High or Low Blood Pressure			
Shingles			
Kidney Problems			
Mononucleosis			
Pneumonia			
Rheumatic fever			
Sinus Problems			
Sleep Apnea			
Stroke			
Thyroid Problems			
Other (describe)			
Injuries	**Yes**	**No**	**Date**
Head Injury			
Neck Injury			
Back Injury			
Fracture			
Other (describe)			

Health Conditions	Last 60 Days	Ever	Never	Date
Loss of Sleep				
Anemia				
Vaccine Adverse Event				
Bruise Easily				
Constipation/Diarrhea				
Varicose Veins				
Hot Flashes				
Arthritis				
Dizziness				
Diabetes				
Congenital Heart Detect				
Loss of Memory				
Cancer				
Psychiatric Problems				
Loss of Balance				
Seasonal Allergies				
Other (describe)				

Operations	Yes	No
Tonsillectomy		
Tubes in Ears		
Appendectomy		
Gall Bladder		
Full Hysterectomy		
Partial Hysterectomy		
Dental Surgery		
Other (describe)		
Hospitalizations		
When	**For What Reason**	

Family History

1. Does anyone in your family suffer with the same condition(s)? No Yes If yes, whom?
   grandmother grandfather mother father sister(s) brother(s) daughter(s) son(s)
   Have they ever been treated for their condition? No Yes I don't know
2. Any other hereditary conditions the doctor should be aware of? No Yes: _____

Sleep

Average number of hours you sleep? _____ Do you have trouble falling asleep? ◯ Yes ◯ No

Do you feel rested upon awakening? ◯ Yes ◯ No Do you have problems with insomnia? ◯ Yes ◯ No

Do you snore? ◯Yes ◯ No Do you use sleeping aids? ◯ Yes ◯ No Explain: _____

Toxicity

Currently using tobacco? Yes No How many years? _____ Packs/Cans per day _____ Previous ? How many years? _____

If yes currently or in the past, what type? Cigarette Smokeless/Chewing Cigar/Pipe Patch/Gum

Are you exposed to 2nd hand smoke? Yes No Explain

_____

How many drinks currently per week? None 1-3 4-5 7-10 More than 10

Previous alcohol intake? Yes No If yes, was it Mild Moderate High

Are you currently taking a blood thinner? (Coumadin, Lovenox, Heparin, Aspirin, etc) Yes No

Are you currently taking a Statin? (Atorvastatin, Lipitor, Crestor, Simvastatin, etc) Yes No

Do you exercise regularly? Yes No If yes, describe type and how often?_____

Do you have any mercury or amalgam fillings? Yes No If yes, how many? ___

How often do you consume processed breads, flours, and grains? _____

How may vaccines have you had in your life? _____

Have you recived the Covid Vaccine? Yes No Number of Boosters _____

Women Specific

Check the box if yes and provide number.

☐ Pregnancies ____ ☐ Miscarriage ____ ☐ Living Children ____ ☐ Abortion ____ ☐ Cesarean ____

☐ Vaginal Delivery ____ ☐ Postpartum Depression ____ ☐ Toxemia ____ ☐ Baby Over 8 Pounds ____

☐ Gestational Diabetes ____ ☐ Breast Implants

Menstrual History

Age At 1st Period _____ Menses Frequency _____ Length _____

Painful? ◯Yes ◯ No Clotting? ◯Yes No Have you ever missed your period? ◯ Yes ◯No

For how long? _____ Are you menopausal? ◯Yes ◯ No Age At Menopause _____

Last Menstrual Period _____

Do you take any hormone contraception? Yes No Birth Control Pill _____

IUD _____ Injection _____ Implant _____

INSURANCE INFORMATION

Primary Insurance Information

Insurance Company Name _____ Plan Name _____

Phone # _____ Primary ID/Policy _____ Primary Group # _____

Policy Holder's Name _____ Policy Holder's DOB _____

If you are NOT the Policy Holder, what is your relation to the Policy Holder? _____

For verification puposes, what is the Policy Holder's Social Security Number? _____

Secondary Insurance Information

Insurance Company Name _____ Plan Name _____

Phone # _____ Secondary ID/Policy _____ Secondary Group # _____

Policy Holder's Name _____ Policy Holder's DOB _____

If you are NOT the Policy Holder, what is your relation to the Policy Holder? _____

For verification puposes, what is the Policy Holder's Social Security Number? _____

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to condition as the practitioners see fit.

I hereby authorize 180 Health Solutions to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of the authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. Verifying insurance benefits does not guarantee payment from my insurance company. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself.

In understand that there is a **3 business day** cancellation policy for a new patient and consultation appointments. failure to comply with the cancellation policy may result in a additional charges. A $25 fee will be applied to all NSF checks. I agree to the financial policy described above and will adhere to all its practices Please email this completed form to **frontdesk@180healthnow.com.**

By typing or signing your name below on the signature line, you are agreeing to all of the paragraph above.

_____ _____

Signature Date Physician Signature Date