Dr. Karl George, Chiropractor, Acupuncturist, 375 Main Street, East Setauket, NY 11733

NAME_____ **DATE**_____

PATIENT HISTORY

Describe your problem or where your pain is most severe.

If pain, does it radiate or spread to other areas? If so, where?

Describe your pain. Is it sharp, stabbing, dull ache, throbbing, pressure, burning, tingling or any other description?

When and how did this present problem occur?

Did it begin suddenly or gradually? Give period of time over which it occurred.

Has it become better or worse?

What makes the condition better or worse, such as body position (sitting, standing, lying), movement, heat, cold, exercise, rest, etc.?

Better:

Worse:

Is there any time of day that it is better or worse?

Have you ever had this or any similar condition before?
If so, when and what treatment did you receive?

Have you ever consulted any other doctor for this condition? If so, with whom and what was the diagnosis?

Are you presently taking any medications? If so, what medications, supplements or herbs?

If known, what do you believe is the cause of your problem?

PERSONAL HISTORY

KARL G. GEORGE, D.C., P.C.
375 MAIN STREET
EAST SETAUKET, N.Y. 11733
631, 751-0900

Date: _____ Social Security No.: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell: _____
Email Address: _____ Cell carrier: _____
Birthdate: _____ Age: _____ Sex: M F

Business/Employer: _____ Type of Work: _____

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated No. of Children _____

Name of Emergency Contact: _____ Phone No.: _____

Referred To This Office By: _____

Who is Responsible For Your Bill: ☐Self ☐ Spouse ☐ Workman's Comp. ☐ Medicaid
☐Medicare ☐Auto Insurance ☐Personal Health Insurance ☐ Other _____

CURRENT HEALTH CONDITION

Purpose of This Appointment: _____

_____

Other Doctors Seen For This Condition: _____

When Did This Condition Begin: _____

If Disabled From Work Please Give Dates: _____

☐ Job related ☐ Auto related
Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine
☐Insulin ☐ Other:

PAST HEALTH HISTORY

Please Check or Describe:

Major Surgery/Operations: ☐Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia
☐Broken Bones: ☐ Other: _____

Major Accidents or Falls: _____

_____

Hospitalization (Other Than Above): _____

_____

Previous Chiropractic Care: ☐ None Acupuncture Treatment? ☐ None
☐ Doctor's Name & Approx. Date of Last Visit: _____
Have you been treated for any health condition in the last year? ☐ Yes ☐ No

If yes, please explain: _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Appendicitis
- ☐ Scarlet Fever
- ☐ Diptheria
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Eczema

CHECK ANY OF THE FOLLOWING YOU **HAVE** OR **HAVE HAD** THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking jaw

NERVOUS SYSTEM CODE

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

GENERAL CODE

- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling

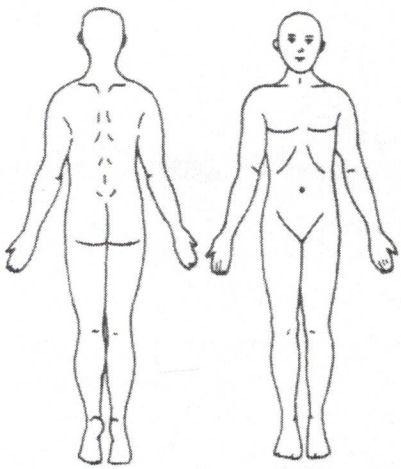
EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes

FEMALES ONLY:
When was your last period?_____
Are you pregnant? ☐ Yes ☐ No ☐ Maybe



Please outline on the diagram the area of your discomfort.

KARL G. GEORGE, D.C., P.C.
375 MAIN STREET
EAST SETAUKET, N.Y. 11733
631, 751-0900

DO NOT WRITE BELOW THIS LINE

Diagnosis:
Patient Accepted: ☐ Yes ☐ No

_____
Doctor's Signature