The Link
Spine and Sports Rehabilitation
Your Link to Health

1374 East 36th Street, Suite 2801 B
Cleveland, OH 44114
P: 216-400-7474 F: 216-400-7733
www.yourlinktohealth.com

HEALTH HISTORY INFORMATION

All information you supply is confidential according to HIPPA.

___________ ____
Today's Date Please List your Primary Doctor's Name and Phone #

____ O Male O Female ________________
First Name Middle Initial Last Name Social Security #

____ __________ Married? OYes ONo
Street Address Birth Date

____________________ ____ ________ (____)__________ (____)__________ (____)__________
City State Zip Code Home Phone Cell Phone Work Phone

____________________________________ ________________________ (____)__________
Email Address Emergency Contact Person Phone

____________________ ___________________________ May we contact you at work? OYes ONo
Your Occupation Employer's Name

_____________________________ _________________ Who carries policy? OSelf OSpouse OParent
Insurance Carrier Policy Number

____ ___________________________
Insured's First Name Middle Initial Last Name Insured's Employer

INJURY OR ILLNESS INFORMATION

What is the current reason that you are seeking care/evaluation at our office? OWork Injury OCar Accident OHealth/Wellness

When did this problem begin? __________________________ OEvaluation ONutrition OOther____________

Describe the Injury/Illness:____

____ ____________
Current Symptoms/Complaints: **Pain Level (0 – 10)**

What type of pain are you having? ODull/Achy OThrobbing OSharp OStiffness OBurning ONumbness/Tingling OStabbing

Do the Symptoms travel anywhere? _______________________________________ O Other___________

What makes it worse?____

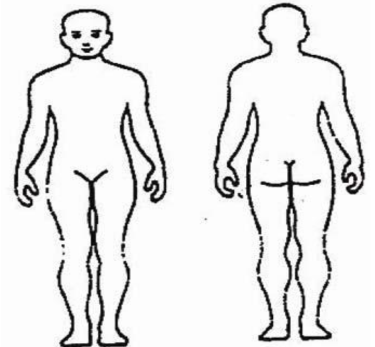
What makes it better?____

Is the pain Constant? OYes ONo If not, how often?________________________

What have you tried to relieve pain? ________________________________

____

Location of your Pain (Mark an X):



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Please list activities (work/home/hobbies/relations) that you cannot do as a result of your symptoms: ________________________

____

Please mark the following that you've had or currently have: O Neck Pain O Back Pain O Shoulder Pain O Elbow/Wrist Pain O Hip Pain O Knee Pain O Ankle/Foot Pain O Headaches O TMJ Issues O Scoliosis O Arthritis O Osteoporosis O Depression O Numbness/Tingling O Anxiety O High Blood Pressure O Low Blood Pressure O High Cholesterol O Heart issues O Asthma O Emphysema O Shortness of Breath O Pneumonia O COPD O Congestive Heart Failure O Anorexia/Bulemia O Food Allergy O Ulcer O Heartburn O Bowel/Bladder Issues O Psoriasis O Hair loss O Other Skin Issues O Thyroid Disorders O Hypoglycemia O Immune Disorders O Chronic Infections O Swollen Glands O Low Libido O Kidney Stones O Prostate Issues O PMS Issues O Erectile Dysfunction O Fainting O Loss of Apetite O Low Energy/Fatigue O Sudden Weight Change O Weakness O Cancer ________________________________
O Other ____

PAST HISTORY/FAMILY HISTORY

Please mark the following injury/illnesses you've had or currently have: O AIDS O Alcoholism O Allergies O Arteriosclerosis O Chicken Pox O Diabetes O Epilepsy O Glaucoma O Goiter O Gout O Heart Disease O Hepatitis O Measles O Multiple Sclerosis O Mumps O Sexually Transmitted Disease O Stroke O Tuberculosis O Rheumatoid Arthritis O Broken Bone O Spine or Nerve Disorder O Knocked Unconscious O Injured in an Accident O Used any Brace/Crutch
O Other ____

Please list any surgeries you have ever had: ____

Please list all current medications/Supplements:____

____

Please List all Disorders in your immediate family and/or causes of death: ______________________________

____

SOCIAL HISTORY/DAILY LIFE

Do you drink alcohol? O Yes O No – How Often? __________ Do you smoke? O Yes O No – How Often? ______________

How many times a week to you Exercise? _________ drink caffeine/coffee? __________ take pain medication? ____________

How much water do you drink per day? __________ Does work cause you stress? ________ Other Stress? ______________

How much sleep do you get per night? _____ Hours What position do you sleep in? __________ How old is mattress? _______

How many meals a day do you eat? ______ Do you snack? ______ Would you say your diet is nutritious? _______________

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Please mark (x) how the following activities are affected by your injury/symptoms:

Sitting	no issue____	limited ____	unable ____	**Self Care**	no issue____	limited ____	unable ____
Standing	no issue____	limited ____	unable ____	**Care of Others**	no issue____	limited ____	unable ____
Walking	no issue____	limited ____	unable ____	**Lifting**	no issue____	limited ____	unable ____
Sleeping	no issue____	limited ____	unable ____	**Reaching**	no issue____	limited ____	unable ____
Climbing Stairs	no issue____	limited ____	unable ____	**Reach Overhead**	no issue____	limited ____	unable ____
Working	no issue____	limited ____	unable ____	**House Chores**	no issue____	limited ____	unable ____
Lying Down	no issue____	limited ____	unable ____	**Exercise**	no issue____	limited ____	unable ____
Bending	no issue____	limited ____	unable ____	**Concentrating**	no issue____	limited ____	unable ____
Using computer	no issue____	limited ____	unable ____	**Enjoying Life**	no issue____	limited ____	unable ____
Driving	no issue____	limited ____	unable ____	**Being Social**	no issue____	limited ____	unable ____

Please tell us what you would like to accomplish to change your health/symptoms: ____

____

Please tell us anything further you feel we may need to know: ____

____

CONSENT FOR TREATMENT

Initials ______ I give my consent for the chiropractic physician to provide treatment that he/she feels medically appropriate for my current injuries/symptoms. I understand that chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials______ I understand that my health records are private and this office follows all the HIPPA regulations and I provide my consent to send my medical records to any insurance company, attorney, or other third party that requires the records for payment of services or requires the medical file.

Initials______ I provide my consent for x-ray examination if the chiropractic physician feels it is medically necessary. I (if female) recognize that x-ray radiation can be hazardous to an unborn child and I provide my consent that I am not pregnant at this time.

Initials_____ 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.

Initials_____ 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.

Initials ____ I grant permission to obtain/review previous bureau of workers compensation claims, as they may affect current complaints.

Initials ____ In the event I received solicitation through phone, mail, or other avenue, I affirm that The Link, Ltd. did not misrepresent themselves as an Insurance Company or the Bureau of Workers Compensation.

Initials____ 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.

For child under the age of 18: ____ ________________
Minors Full Name Date

____ ________________
Print Name Sign Name Date