Tullos Chiropractic

Family & Sports Rehabilitation Clinic, Inc.

DR. DAVID N. TULLOS

3710 I-55 NORTH
JACKSON, MS 39211
PHONE 981-CARE
-2273

CONFIDENTIAL PATIENT INFORMATION

DATE: _____

LAST NAME: _____ *FIRST:* _____ *MIDDLE:* _____
STREET: _____ *CITY:* _____ *STATE:* _____ *ZIP* _____
PHONE: _____ *CELL:* _____ *WORK:* _____
DATE OF BIRTH: _____ *AGE:* _____ *SOCIAL SECURITY #:* _____
EMPLOYER: _____ *CITY:* _____ *STATE:* _____
OCCUPATION: _____ *EMAIL ADDRESS:* _____
NAME OF SPOUSE: _____ *DATE OF BIRTH:* _____
SPOUSE SOCIAL SECURITY # _____ *EMPLOYED BY:* _____
PHONE: _____
NAME OF RELATIVE: _____ *PHONE:* _____
REFERRED TO THIS OFFICE BY: _____
GENERAL PHYSICIAN: _____ *CITY:* _____ *PHONE:* _____
INSURANCE: PRIMARY _____ *SECONDARY* _____

DO NOT WRITE BELOW THIS LINE! (FOR DOCTOR) _____

CHIROPRACTIC/HEALTH COMPREHENSIVE HEALTH QUESTIONNAIRE

TULLOS CHIROPRACTIC CLINIC, INC.
FAMILY & SPORTS REHAB. 981-CARE
3710 I-55 NORTH
JACKSON, MS 39211

Patient Name _____

Reason for visit _____

Have you been treated before for this problem? ☐ No ☐ Yes

If yes, by ☐ Physician ☐ Doctor of Chiropractic ☐ Physical Therapist ☐ Osteopath ☐ Other _____

What did they do and/or recommend? _____

When did your symptoms appear? _____ Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Is it constant or does it come and go? _____ Does it interfere with your ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down

Other _____

List any Surgeries or Hospitalizations: _____

Have you ever had chiropractic care for other problems? ☐ No ☐ Yes ☐ When? _____

Do you take ☐ Muscle relaxers ☐ Pain killers ☐ Insulin ☐ Birth control pills ☐ Over-the counter meds

☐ Other prescription drugs _____ Please list all medications in the space at bottom of page.

Date of last: Physical exam _____ Spinal x-ray _____ Blood test _____

Spinal exam _____ Chest x-ray _____ Urine test _____

Dental x-ray _____ MRI, CT-scan, bone scan _____

Sleep _____ hrs/night Do you sleep on your ☐ Back ☐ Side ☐ Stomach Non-job exercise _____ hrs/wk

List any auto accidents, slips or falls: _____ Is your bed comfortable ☐ No ☐ Yes

What kind of pillow do you use? ☐ Thick ☐ Medium ☐ Thin ☐ None ☐ Support

Do you wear ☐ Heel lifts ☐ Shoe lifts ☐ Arch supports ☐ Orthotics, describe _____

CONDITIONS Check (✓) conditions you have or have had in the past

☐ AIDS	☐ Diabetes	☐ Liver disease	☐ Rheumatic fever
☐ Alcoholism	☐ Emphysema	☐ Measles	☐ Scarlet fever
☐ Anemia	☐ Epilepsy	☐ Migraine headaches	☐ Stroke
☐ Anorexia	☐ Fractures	☐ Miscarriage	☐ Suicide attempt
☐ Appendicitis	☐ Glaucoma	☐ Mononucleosis	☐ Thyroid problems
☐ Arthritis	☐ Goiter	☐ Multiple sclerosis	☐ Tonsillitis
☐ Asthma	☐ Gonorrhea	☐ Mumps	☐ Tuberculosis
☐ Bleeding disorders	☐ Gout	☐ Osteoporosis	☐ Tumors, growths
☐ Breast lump	☐ Heart disease	☐ Pacemaker	☐ Typhoid fever
☐ Bronchitis	☐ Hepatitis	☐ Pneumonia	☐ Ulcers
☐ Bulimia	☐ Hernia	☐ Polio	☐ Vaginal infections
☐ Cancer	☐ Herpes	☐ Prostate problem	☐ Veneral disease
☐ Cataracts	☐ High cholesterol	☐ Prosthesis	☐ Whooping cough
☐ Chemical dependency	☐ HIV positive	☐ Psychiatric care	☐ Other _____
☐ Chicken pox	☐ Kidney disease	☐ Rheumatoid arthritis	_____

MEDICATIONS List medications you are currently taking	**VITAMINS/HERBS/MINERALS**
_____	_____
_____	_____
_____	_____
_____	_____
Allergies _____	
Pharmacy Name _____ Phone _____	

GENERAL SYMPTOMS: Check (✓) symptoms you currently have or have had in the past year

GENERAL
- ☐ Bruise easily
- ☐ Chills
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Liver
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Tiredness
- ☐ Weight gain

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Kidney problems

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Colon
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - flashes
- ☐ Vision - halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

NECK, BACK, EXTREMITIES: Check (✓) symptoms you currently have or have had in the past year

NECK
- ☐ Pain in neck
- ☐ Neck stiffness
- ☐ Neck weakness
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasm in neck
- ☐ Grinding/popping sounds in neck

SHOULDERS — Right / Left
- ☐ Pain in shoulder joint ☐R ☐L
- ☐ Pain across shoulders
- ☐ Can't raise arm ☐R ☐L
  - ☐ Above shoulder level
  - ☐ Over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder ☐R ☐L

MID-BACK
- ☐ Mid-back pain
- ☐ Mid-back stiffness
- ☐ Pain between should blades
- ☐ Pain from front to back
- ☐ Muscle spasms in mid-back

ARMS & HANDS — Right / Left
- ☐ Pain in upper arm ☐R ☐L
- ☐ Pain in elbow ☐R ☐L
- ☐ Pain in forearm ☐R ☐L
- ☐ Pain in hand ☐R ☐L
- ☐ Pain in fingers ☐R ☐L
- ☐ Pins & needles in arm ☐R ☐L
- ☐ Pins & needles in fingers ☐R ☐L
- ☐ Numbness in arm ☐R ☐L
- ☐ Numbness in fingers ☐R ☐L
- ☐ Weakness of arm ☐R ☐L
- ☐ Weakness of hand ☐R ☐L
- ☐ Hands cold ☐R ☐L

LOW BACK
- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back weakness
- ☐ Pinched nerve in low back
- ☐ Low back feels out of place
- ☐ Muscle spasms in low back

HIPS, LEGS & FEET — Right / Left
- ☐ Pain in buttocks ☐R ☐L
- ☐ Pain in hip joint ☐R ☐L
- ☐ Pain down leg ☐R ☐L
- ☐ Pain in knee ☐R ☐L
- ☐ Pain in ankle ☐R ☐L
- ☐ Pain in foot ☐R ☐L
- ☐ Weakness of leg ☐R ☐L
- ☐ Weakness of knee ☐R ☐L
- ☐ Leg cramps ☐R ☐L

OTHER SYMPTOMS

_____

_____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient Signature Date

Reviewed by: _____ _____

Doctor Date