

INNER SHORES CHIROPRACTIC & HOMEOPATHY

Dr. Wendy Pollock, D.C., PA  
83 India St., Wildwood Medicine  
Portland, Maine 04101  
207 370-8330

Date:

Patient Information Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

HomePh# \_\_\_\_\_ WorkPh# \_\_\_\_\_

Emergency Contact Name & Number

Employer: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Would you like an appointment reminder phone call? \_\_\_\_\_

Email address: \_\_\_\_\_

**Reason for your visit:**

**Primary Health Insurance**

Name of Insurance Co. \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Certificate# \_\_\_\_\_ Group# \_\_\_\_\_

**Secondary Health Insurance**

Name of Insurance Co. \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Certificate# \_\_\_\_\_ Group# \_\_\_\_\_

Is this related to a workers comp, auto liability or personal injury claim? Yes No

**Medical Records Release and Assignment of Benefits**

I authorize the release of any medical records necessary to process any claims for services rendered to me by Dr. Wendy Pollock. I realize that if for any reason these services are not covered by the insurance(s) listed above; I am fully liable for any unpaid services

**Signature** of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize payment of benefits to be released directly to the above provider:

**Signature** of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

<b>INNER SHORES</b>	<b>Original Date:</b>	
	<b>Dates Revised:</b>	
	<b>Soc. Sec. #:</b>	
<b>DR. WENDY POLLOCK, D.C., PA</b> 83 India Street, Wildwood Medicine Portland, Maine 04101		

## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Additional space is provided on the last page.

<b>Name</b> <i>(Last, First, M.I.):</i>		<b>DOB:</b>	
<b>Marital status:</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Partnered	<input type="checkbox"/> Married
	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
<b>Previous or referring doctor:</b>		<b>Date of last physical exam:</b>	
<b>Gender Identification:</b>			

### PERSONAL HEALTH HISTORY

<b>Childhood illness:</b>	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Polio
<b>Immunizations and dates:</b>	<input type="checkbox"/> Tetanus, diphtheria, pertussis			<input type="checkbox"/> Pneumonia		
	<input type="checkbox"/> Hepatitis			<input type="checkbox"/> Chickenpox		
	<input type="checkbox"/> Influenza			<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>		
	<input type="checkbox"/> HPV Vaccine for Men			<input type="checkbox"/> HPV Vaccine for Women		
	<input type="checkbox"/> Zoster (Shingles)			Meningococcal		
	<input type="checkbox"/> Hepatitis A			Hepatitis B		
	<input type="checkbox"/> Polio					

**Describe any adverse reactions to immunizations:**

**List any medical problems/injuries, even those that occurred in childhood.** Include Birth difficulties/trauma, head trauma/concussion, dental work, vehicle accidents, falls, sports injuries, emotional trauma. Include the **date** as best you can recall.

#### Surgeries

Year	Reason	Hospital

#### Other hospitalizations

Year	Reason	Hospital

**Have you ever had a blood transfusion?**  yes  No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY	
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.	
<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

<b>Diet</b>	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	# of meals you eat in an average day?			
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low

<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			

<b>Alcohol</b>	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No
	Are you concerned about the amount you drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you considered stopping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you ever experienced blackouts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

<b>Tobacco</b>	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	# of years	Or year quit _____	<input type="checkbox"/> Chew - #/day _____	<input type="checkbox"/> Pipe - #/day _____	<input type="checkbox"/> Cigars - #/day _____

<b>Drugs</b>	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Sex</b>	Are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	Explain:	
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Person Safety</b>	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>FAMILY HEALTH HISTORY</b>					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE AND GENDER	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>		
<b>Mother</b>					
<b>Sibling</b>	Gender				
			<b>Grandmother</b> <i>Maternal</i>		
			<b>Grandfather</b> <i>Maternal</i>		
			<b>Grandmother</b> <i>Paternal</i>		
			<b>Grandfather</b> <i>Paternal</i>		

<b>MENTAL HEALTH</b>		
Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>WOMEN ONLY</b>		
Age at onset of menstruation:		
Date of last menstruation:		
Period how many days:		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies:	Number of live births:	
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?:		

<b>MEN ONLY</b>		
Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times:		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?		

<b>OTHER PROBLEMS</b>			
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.			
<input type="checkbox"/>	Skin	<input type="checkbox"/>	Chest/Heart
<input type="checkbox"/>	Head/Neck	<input type="checkbox"/>	Back
<input type="checkbox"/>	Ears	<input type="checkbox"/>	Intestinal
<input type="checkbox"/>	Nose	<input type="checkbox"/>	Bladder
<input type="checkbox"/>	Throat	<input type="checkbox"/>	Bowel
<input type="checkbox"/>	Lungs	<input type="checkbox"/>	Circulation
<input type="checkbox"/>		<input type="checkbox"/>	Recent changes in:
<input type="checkbox"/>		<input type="checkbox"/>	Weight
<input type="checkbox"/>		<input type="checkbox"/>	Energy level
<input type="checkbox"/>		<input type="checkbox"/>	Ability to sleep
<input type="checkbox"/>		<input type="checkbox"/>	Other pain/discomfort:
Explanation for items checked above. Continue on to the next page if necessary			

**ADDITIONAL EXPLANATIONS, FROM OTHER PAGES:**
