INNER SHORES CHIROPRACTIC & HOMEOPATHY
Dr. Wendy Pollock, D.C., PA
innershores@gmail.com
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:_____

INNER SHORES

Original Date:	
Dates Revised:	
Soc. Sec. #:	

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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.

Name *(Last, First, M.I.):*		**DOB:**	
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:		**Date of last physical exam:**	
Gender Identification:			

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	☐ Tetanus, diphtheria, pertussis	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*
	☐ HPV Vaccine for Men	☐ HPV Vaccine for Women
	☐ Zoster (Shingles)	Meningococcal
	☐ Hepatitis A	Hepatitis B
	☐ 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.	
Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	

Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			

Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	Are you concerned about the amount you drink?	☐ Yes	☐ No
	Have you considered stopping?	☐ Yes	☐ No
	Have you ever experienced blackouts?	☐ Yes	☐ No

Tobacco	Do you use tobacco?			☐ Yes	☐ No
	# of years	Or year quit _____	☐ Chew - #/day ____	☐ Pipe - #/day _____	☐ Cigars - #/day_____

Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
	Are you sexually active?	☐ Yes	☐ No

Sex	Are you trying for a pregnancy?	☐ Yes	☐ 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?	☐ Yes	☐ No

Person Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ 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?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE AND GENDER	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**		
Mother					
Sibling	Gender				
			Grandmother *Maternal*		
			Grandfather *Maternal*		
			Grandmother *Paternal*		
			Grandfather *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY			
Age at onset of menstruation:			
Date of last menstruation:			
Period how many days:			
Heavy periods, irregularity, spotting, pain, or discharge?		☐ Yes	☐ No
Number of pregnancies:	Number of live births:		
Are you pregnant or breastfeeding?		☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?		☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?		☐ Yes	☐ No
Any blood in your urine?		☐ Yes	☐ No
Any problems with control of urination?		☐ Yes	☐ No
Any hot flashes or sweating at night?		☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?		☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?		☐ Yes	☐ No
Date of last pap and rectal exam?:			
MEN ONLY			
Do you usually get up to urinate during the night?		☐ Yes	☐ No
If yes, # of times:			
Do you feel pain or burning with urination?		☐ Yes	☐ No
Any blood in your urine?		☐ Yes	☐ No
Do you feel burning discharge from penis?		☐ Yes	☐ No
Has the force of your urination decreased?		☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?		☐ Yes	☐ No
Do you have any problems emptying your bladder completely?		☐ Yes	☐ No
Any difficulty with erection or ejaculation?		☐ Yes	☐ No
Any testicle pain or swelling?		☐ Yes	☐ No
Date of last prostate and rectal exam?			

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

ADDITIONAL EXPLANATIONS, FROM OTHER PAGES: