Dr. Dakota Parris, D.C.
Root to Branch Healing House
980 Main Street
Bryson City, NC 28713
828-736-0326

PERSONAL HISTORY

DATE: ____________________

Who is responsible for your bill: ______________________________ Relationship: ________________

(Please Note: Payment is expected at the time services are rendered unless other arrangements have been made with our office prior to your visit.)

PERSONAL INFORMATION

Preferred Name: ______________________ **Date of Birth:** ___/___/_____ **Age:** ________ **Gender:** ____________

First Name: _______________ **Middle Name:** ______________ **Last Name:** __________________________ **Suffix:** _____

Local Mailing Address: ______________________________ **City:** ______________ **State:** _____ **Zip:** ________

Home Phone: _________________ **Cell Phone:** __________________ **Email:** ________________________

Appointment Reminder Method: ☐ Text Me (Cell Phone Provide:_______________) ☐ Email Me

(Please Note: Reminder calls/texts/emails are a courtesy. You are responsible for you appointment whether your reminder was received or not.)

How did you hear about us or, who referred you? ______________________________

MARITAL STATUS: ☐ Single ☐ Married (Spouse/Partner Name: ____________________ #of Children______) ☐ Widowed

EMPLOYMENT STATUS: ☐ Employed ☐ FT Student ☐ PT Student ☐ Retired ☐ Self-Employed ☐ Other

Employer and/or Type of Work: ______________________________

RACE: ☐ White ☐ Asian ☐ Japanese ☐ Samoan ☐ Black/African American ☐ Asian Indian ☐ Korean ☐ Chinese ☐ Vietnamese ☐ Guamanian or Chamorro ☐ Hispanic ☐ American Indian/Alaskan Native ☐ Filipino ☐ Native Hawaiian/Pacific Island ☐ Other ________________ ☐ I choose not to specify **Preferred Language:** ☐ English ☐ Other______________

HEALTH HISTORY

Purpose fo this Appointment ______________________ **Other Doctors seen for this condition:** ________________

When did this condition begin: __________________ **Is it:** ☐ Job-related ☐ Auto related ☐ Home accident

Major Surgery/Operations: ☐ Appendectomy ☐ Cancer-related ☐ Gall Bladder ☐ Hernia ☐ Spinal ☐ Hysterectomy ☐ Broken Bones

Other: ______________________ Hospitalizations (other than above) ______________________________

ACCIDENTS/FALLS HISTORY

Includes auto/work/sport-related jolts, traumas, etc., and ALL EVENTS which could have any impact upon the spine are of high significance to determine spinal health history. Please fill-out completely.

Within the past year - when/describe: ______________________________________

Over a year ago - when/describe______________________ **Childhood** - when/describe______________________

Previous Chiropractic Care? ☐ **Yes** ☐ **No** where/when:______________________________

WOMEN ONLY: Are you pregnant? ☐ **Yes** ☐ **No**

Pregnancy Release: This is to certify that to the best of my knowledge, I am not pregnant, and the above doctor and her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ____________ **Signature:**______________________________ **Date:** ____________

Do you currently use tobacco of any kind: ☐ **Yes** ☐ **No** ☐ **Former Smoker**

If yes, how often: ☐ Currently everyday smoker/user ☐ Current smoker/user sometimes

Interested in Quitting: ☐ 0 (No Interest) ☐ 5 (Somewhat Interested) ☐ 10 (Very Interested)

HEIGHT: ______________ **WEIGHT:** __________ **BLOOD PRESSURE:** __________________ **PULSE:** ____________

MEDICATIONS

LIST YOUR CURRENT MEDICATIONS

MEDICATION	DOSAGE	FREQUENCY

☐ Check box if you're not currently taking medications.

LIST MEDICATIONS YOU ARE ALLERGIC TO

MEDICATION	REACTION	DATE BEGAN

☐ Check box if you do not have any known allergies.

Has any doctor diagnosed you with Hypertension (high blood pressure) presently? ☐ Yes ☐ No If yes, when? ________________

Has any doctor diagnosed you with Diabetes presently? ☐ Yes ☐ No If yes, what kind? ☐ Type I ☐ Type II

Have you had an x-ray, CT scan, or MRI of your spine in the past 28 days? ☐ Yes ☐ No If yes, where? ________________________

Do you purchase any vitamins or health food products? ☐ Yes ☐ No

Exercise regularly? ☐ Yes ☐ No If yes, how often? ____________________ / week

We offer advice on nutritional supplementation, weight loss, and detox. Are you interested in learning more? ☐ Yes ☐ No

Please check any of the following that give you difficulty and you have had recently:

GENERAL	SKIN	EYE/EAR/NOSE/THROAT	SHOULDERS	MID BACK
☐ Headaches	☐ Bruise easily	☐ Sinus trouble/Allergies	☐ Shoulder/arm tightness	☐ Mid-back pain/stiffness
☐ Shooting head pain	☐ Hives	☐ Loss of smell	☐ Shoulder/arm pain	☐ Spinal curvature
☐ Loss of memory	☐ Itching/Rash	☐ Hay fever	☐ Pain in shoulder joint	☐ Pain betw. shoulder blades
☐ Fatigue	☐ Sore that won't heal	☐ Asthma	☐ Pain across shoulders	☐ Muscles spasms
☐ Depression	**GASTROINTESTINAL**	☐ Loss of taste	☐ Can't raise arms	**LOW BACK**
☐		☐	☐	
☐ Dizziness	☐ Bowel changes	☐ Inflammation of throat	☐ Tension in Shoulders	☐ Low back pain/stiffness
☐ Thyroid trouble	☐ Intestinal gas	☐ Earache	☐ Pinched nerve in shoulder	☐ Low back weakness
☐ Thyroid trouble	☐ Intestinal gas	☐ Hoarseness	**CARDIOVASCULAR**	☐ Low back feels out of place
☐	☐	☐		☐
☐ Sleeping problems	☐ Constipation	☐ Loss of hearing	☐ Chest pain	☐ Muscle spasms in low back
☐ Seizures	☐ Indigestion	☐ Loss of hearing	☐ Heart attacks	☐ HIPS, LEGS, FEET
☐ Fainting	☐ Nausea	☐ Persistent cough	☐ Stroke	☐ Pain in hip joint
☐ Irritability	☐ Stomach issues	☐ Ringing in ears	☐ High blood pressure	☐ Pain down leg
☐ Stress	☐ Vomiting	☐ Blurred vision	☐ Poor circulation	☐ Pain in knee
☐ Weight gain	☐ Gall bladder trouble	☐ Vision (flashes/halos)	☐ Irregular heart beat	☐ Pain in ankle
☐ Facial pain/twitch	**ARMS & HANDS**	☐ Tonsillitis	☐ Rapid heart beat	☐ Pain in foot
☐ Jaw pain ™	☐ Pins & needles in arms/hands	☐ Lights bother eyes	☐ Swollen ankles	☐ Weakness of leg
☐ Menstrual cramps/pain	☐ Numbness in arms/hands	**NECK**	☐ Cold feet	☐ Weakness of knee
☐ Menstrual irregularity	☐ Pain in upper arm	☐ Neck pain/stiffness	☐ Anemia	☐ Leg cramps
☐ Loss of balance	☐ Pain in elbow	☐ Grinding/popping in neck	☐	☐ Pins & needles in legs
☐ Prostate trouble	☐ Pain in forearm	☐ Pinched nerve in neck	☐	☐ Numbness in legs/feet
☐ Hernia	☐ Pain in hand/fingers	☐ Neck feels out of place	☐	
☐ Arthritis	☐ Weakness of hand	☐ Muscle spasms in neck	☐	
☐ Ulcers	☐ Cold hands	☐	☐	

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 ommissions that I may have made in the completion of this form.

Patient Signature: ____ Date: ________________

(If under age 18) Parent's Signature: ________________________________ Date: ________________