Patient Health History

Name: _____ Age: _____ Date of Birth: _____ Sex: □ M □ F
Address: _____ City: _____ State: _____ Zip: _____
Phone (Home): _____ (Work): _____ (Cell): _____
E-mail Address: _____ Marital Status: □ S □ M □ D □ W Number of Children: _____
Occupation: _____ Social Security Number: _____
Employer: _____ Driver's License Number: _____
Spouse's Name: _____ Spouse's Age: _____ Spouse's Date of Birth: _____
Spouse's Occupation: _____ Spouse's Social Security Number: _____
Spouse's Employer: _____ Spouse's Phone (Cell or Work): _____
Insured's Name: _____ Insured's Phone: _____ Insured's Date of Birth: _____
Insurance Company: _____ Spouse's Insurance Company: _____
How did you hear about our office: _____ Referred By: _____
Past Chiropractic Care: □ Y □ N When? _____ Doctor's Name: _____ Results: _____

Are your present problems due to an injury? □ Y □ N □ On Job □ Auto Accident □ Personal Injury □ Other: _____
Has the accident been reported? □ Y □ N □ To Employer □ Auto Carrier □ Other: _____
You now or have you ever been disabled? (Service or Work)? □ Y □ N When? _____
Have you retained an attorney? □ Y □ N Name & Address: _____

What is your current work status?

□ Full time, no restrictions □ Full time, restrictions □ Full time Homemaker □ Full time Student
□Part time, no restrictions □ Part time, restrictions □ Retired □ Unemployed
□ Off work due to restrictions □ Other: _____

Restrictions:

Off Work: □ Y □ N □ Preciously From: _____ to _____
Light Duty: □ Y □ N □ Previously (If yes, what are/were restrictions?) _____

Do/did you require outside help at home?

□ Y □ N (If yes, what help do/did you need?) _____

List any accidents or falls and dates: □ Auto: _____ □ Recreation: _____
□ Sports: _____ □ Work Related: _____ □ Other: _____
List any broken bones (fractures) or dislocations: _____
Ever on crutches? □ Y □ N Why? _____
Were you ever knocked unconscious? □ Y □ N (If yes please explain): _____
Have you ever had x-rays taken? □ Y □ N When? _____ By Whom: _____
For what ailments were these x-rays taken? _____
Do you wear orthotics or heal lifts? □ Y □ N If yes, fitted by whom? _____ When? _____
Do you suffer from any condition other than that for which you are now consulting us? □ Y □ N _____
Are you presently taking any medication, prescription, over-the-counter, home remedy, vitamins, minerals, etc?
(Please list) _____

OPERATIONS AND PROCEDURES

□ I have never had any operations and surgeries

_____ Date: _____ _____ Date: _____
_____ Date: _____ _____ Date: _____

Please check the correct box for each item below. Check at least one box for each sign or symptom list. ☐ Never ☐ Previously ☐ Present

Never Previously Presently

GENERAL SYMPTOMS

☐ ☐ ☐ Allergy (What) ____

_____

☐ ☐ ☐ Bronchitis
☐ ☐ ☐ Chills (Constant)
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of Sleep
☐ ☐ ☐ Loss of Weight
☐ ☐ ☐ Nervousness
☐ ☐ ☐ Night Sweats
☐ ☐ ☐ Numbness or Pain In arms/legs/hands
☐ ☐ ☐ Wheezing

MUSCLES & JOINTS

☐ ☐ ☐ Backache
☐ ☐ ☐ Foot Trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Pain Between Shoulders
☐ ☐ ☐ Painful Tail Bone
☐ ☐ ☐ Stiff Neck
☐ ☐ ☐ Spinal Curvature
☐ ☐ ☐ Swollen Joints
☐ ☐ ☐ Tremors
☐ ☐ ☐ Twitching

Never Previously Presently

GASTRO-INTESTINAL

☐ ☐ ☐ Belching or Gas
☐ ☐ ☐ Colon Trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Gall Bladder Trouble
☐ ☐ ☐ Hemorrhoids (piles)
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Liver Trouble
☐ ☐ ☐ Nausea
☐ ☐ ☐ Stomach Pain
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting Blood
☐ ☐ ☐ Heart Burn
☐ ☐ ☐ Bloody Stools
☐ ☐ ☐ Acid Reflux
☐ ☐ ☐ Irritable Bowel

CARDIO-VASCULAR

☐ ☐ ☐ High Blood Pressure
☐ ☐ ☐ Low Blood Pressure
☐ ☐ ☐ Chest Pain
☐ ☐ ☐ Heart Trouble
☐ ☐ ☐ Poor Circulation
☐ ☐ ☐ Rapid Heart
☐ ☐ ☐ Slow Heart
☐ ☐ ☐ Strokes
☐ ☐ ☐ Swelling Ankles
☐ ☐ ☐ Varicose Veins

Never Previously Presently

EYE/EAR NOSE/THROAT

☐ ☐ ☐ Asthma
☐ ☐ ☐ Deafness
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear Discharge
☐ ☐ ☐ Ear Noises
☐ ☐ ☐ Thyroid Problems
☐ ☐ ☐ Frequent Colds
☐ ☐ ☐ Hay Fever
☐ ☐ ☐ Nasal Obstruction
☐ ☐ ☐ Nose Bleeds
☐ ☐ ☐ Pain in Eyes
☐ ☐ ☐ Poor Vision
☐ ☐ ☐ Blurred Vision
☐ ☐ ☐ Sinusitis
☐ ☐ ☐ Sore Throats
☐ ☐ ☐ Tonsillitis

SKIN OR ALLERGIES

☐ ☐ ☐ Bruising Easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Eczema
☐ ☐ ☐ Hives or Allergy
☐ ☐ ☐ Itching
☐ ☐ ☐ Sensitive Skin
☐ ☐ ☐ Skin Eruptions

Never Previously Presently

RESPIRATORY

☐ ☐ ☐ Chest Pain
☐ ☐ ☐ Chronic Cough
☐ ☐ ☐ Difficulty Breathing
☐ ☐ ☐ Spitting Blood
☐ ☐ ☐ Spitting Phlegm

GENITO-URINARY

☐ ☐ ☐ Bed Wetting
☐ ☐ ☐ Blood in Urine
☐ ☐ ☐ Frequent Urination
☐ ☐ ☐ Inability to Control Urine
☐ ☐ ☐ Kidney Infection
☐ ☐ ☐ Kidney Stones
☐ ☐ ☐ Painful Urination
☐ ☐ ☐ Prostate Trouble

FOR FEMALES ONLY

☐ ☐ ☐ Cramps
☐ ☐ ☐ Hot Flashes
☐ ☐ ☐ Irregular Cycle
☐ ☐ ☐ Painful Periods
☐ ☐ ☐ Vaginal Discharge
☐ Yes ☐ No Pregnant at this time
_____ Last Pap Date
_____ Last Menstrual Cycle

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING DISEASES?

☐ Appendicitis	☐ Anemia	☐ Heart Disease	☐ Arthritis	☐ Pneumonia	☐ Measles
☐ Goiter	☐ Epilepsy	☐ Rheumatic Fever	☐ Mumps	☐ Influenza	☐ Mental Disorder
☐ Polio	☐ Chicken Pox	☐ Pleurisy	☐ Lumbago	☐ Tuberculosis	☐ Diabetes
☐ Alcoholism	☐ Eczema	☐ Whooping Cough	☐ Cancer	☐ HIV Positive	☐ Venereal Disease

HABITS

☐ Smoking Packs/day: _____
☐ Drinking Alcohol: (cups/day) _____
☐ Coffee Cups/day: _____
☐ Soft Drink Bottles or Cans/day: _____
☐ Water Cups/day: _____

EXERCISE

☐ None
☐ Moderate
☐ Daily
Type: _____
_____

FAMILY HISTORY

	Diabetes	Kidney	Cancer	Back
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Brother(s)	☐	☐	☐	☐
Sister(s)	☐	☐	☐	☐

I understand that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider ***will/will not*** prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsibility for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority to these procedures to be performed, it is understood and agreed the amount paid to the Doctor for imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/ Guardian's Signature: _____ Date: _____

CURRENT COMPLAINT HISTORY
(PATIENT)

Patient Name: _____ Date: _____

Please check all boxes that apply to your condition and fill in the spaces that describe your present complaint(s). Also, the information you provide concerning past symptoms will help in assisting the doctor to better understand your present complaints and total health picture.

Please list your present complaint(s) and mark your level of pain today for each complaint- If you have more than one area of complaint, list them in order of the most severe to least severe.

1. _____ Duration- (How Long/ Date): _____ # of Previous Episodes: _____
   Please Circle One (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)
2. _____ Duration- (How Long/ Date): _____ # of Previous Episodes: _____
   Please Circle One (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)
3. _____ Duration- (How Long/ Date): _____ # of Previous Episodes: _____
   Please Circle One (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Has anyone treated you for this episode? □ Yes □ No If yes, by whom? _____
How did your symptoms begin?
☐ Immediately after a specific incident ☐ After multiple incidents ☐ Gradually developed over time □ Other: _____
What makes you symptoms better?
☐ Nothing ☐ Lying down ☐ Standing ☐ Sitting □ Movement/ Exercise ☐ Other: _____
What makes you symptoms worse?
☐ Nothing ☐ Lying down ☐ Standing ☐ Sitting ☐ Movement/ Exercise □ Other: _____

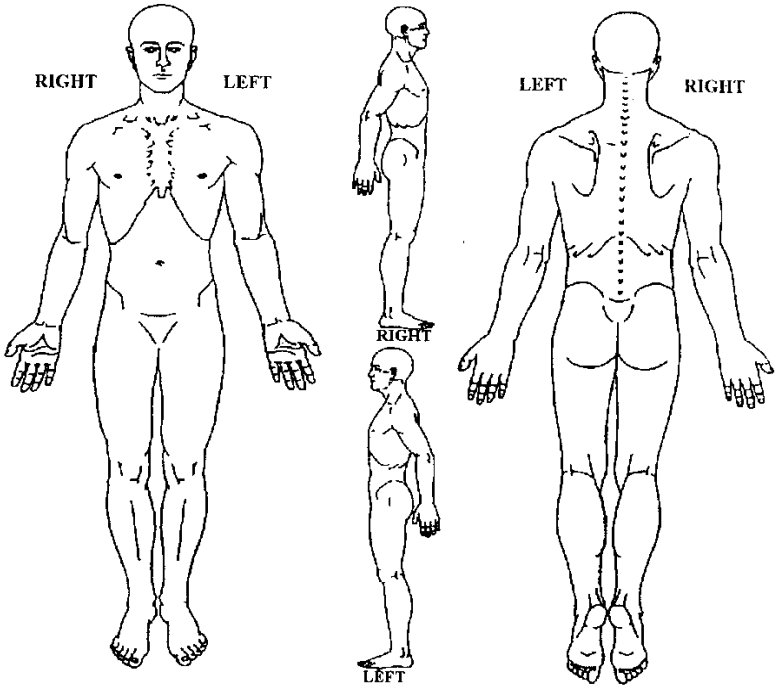
Are your symptoms:
☐ Decreasing ☐ Increasing
☐ Not Changing ☐ Other _____
Description of pain or symptoms:
☐ Sharp ☐ Shooting
☐Dull ☐ Burning
☐ Ache ☐ Numb
☐ Weakness ☐ Tingling
☐ Throbbing ☐ Other _____
Does your pain move or radiate?
☐ Yes ☐ No Where_____
Check the best and worse times of the day for your pain:

Worse	Best
☐ First Awake	☐ First Awake
☐ Morning	☐ Morning
☐ Afternoon	☐ Afternoon
☐ Evening	☐ Evening
☐ Nighttime	☐ Nighttime
☐ Other	☐ Other

_____
Frequency of pain or symptoms:
☐ Constant (76-110%)
☐ Frequent (51-75%)
☐ Occasional (26-50%)
☐ Intermittent (25% or less)

Show us your pain
Use the letter below to indicate the type
and location of your symptoms today

Key: A= ACHE B=BURNING N=NUMBNESS P=PINS & NEEDLES
S=STABBING X=STIFFNESS T=THROBBING O=OTHER



How many days out of an average week are you in pain? (Please circle one) 1 2 3 4 5 6 7
How much time during the day are you in pain?
☐ less than 1 hour ☐ 1-6 hours ☐ 6-12 hours ☐ 12-18 hours ☐ 18-24 hours ☐ 24 hours

Patient/ Guardian Signature: _____Doctor Signature: _____