CONFIDENTIAL PATIENT HISTORY

Name_____ Age_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Phone (____)_____ Date of Birth____/____/____ Sex: M F Marital Status: S M D W # Children_____

Occupation_____ Employer_____ Work Phone (____)_____

Cell Phone (____)_____ E-mail_____ Insured's Name_____

Insured's Date of Birth____/____/____ Spouse's Name_____ Spouse's Occupation_____

Spouse's Employer_____ Spouse's Work Phone (____)_____

Referred by_____ Past Chiropractic Care ❑ Yes ❑ No When_____

Chiropractor's Name_____ Results_____

Nearest relative not living with you_____ Emergency contact/number_____

Insurance Company_____ Insurance Company Phone (____)_____

Social Security #_____-_____-_____ Driver's License #_____

Are your present problems due to an injury? ❑ Yes ❑ No ❑ On the Job ❑ Auto Accident ❑ Other _____

If this is due to an accident, has the accident been reported? ❑ Yes ❑ No ❑ Employer ❑ Auto Insurance Carrier ❑ Other_____

Are you now or have you ever been under disability? ❑ Yes ❑ No Have you retained an attorney? ❑ Yes ❑ No

Attorney's Name_____ Atty. Location/Phone_____

List Current Problems(s)

1._____ Duration (How long)_____ (This episode) Previous Episodes Y/N When_____

2._____ Duration (How long)_____ Previous Episodes Y/N When_____

3._____ Duration (How long)_____ Previous Episodes Y/N When_____

❑ Additional (check here, write on back of this page)

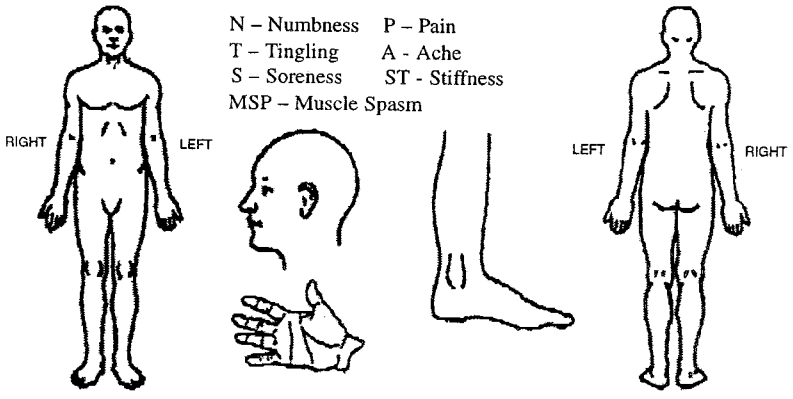
Please mark the intensity of your pain today

0 – No Pain 10 – Excruciating Pain

	Neck (symptom)										
Example:	0	1	2	3	(4)	5	6	7	8	9	10
1.	0	1	2	3	4	5	6	7	8	9	10
2.	0	1	2	3	4	5	6	7	8	9	10
3.	0	1	2	3	4	5	6	7	8	9	10
4.	0	1	2	3	4	5	6	7	8	9	10
5.	0	1	2	3	4	5	6	7	8	9	10

Please circle area and type of pain on the drawings using the code listed below

N – Numbness P – Pain
T – Tingling A - Ache
S – Soreness ST - Stiffness
MSP – Muscle Spasm



Habits

❑ Smoking Packs/Day_____ ❑ Alcohol Amt/Wk_____

❑ Coffee Cups/Day_____ ❑ Soda Cans/Day_____

❑ Eating Habits (Describe)_____

_____

Exercise

❑ None ❑ Health Club

❑ Moderate ❑ At Home

❑ Daily ❑ Other_____

Type_____

Family History of Illnesses

	Diabetes	Heart	Cancer	Headaches	Neck Pain	Back Pain	Other	Deceased
Mother (Age_____)	❑	❑	❑	❑	❑	❑	❑	❑ Age_____
Father (Age_____)	❑	❑	❑	❑	❑	❑	❑	❑ Age_____
Brother (# of _____)	❑	❑	❑	❑	❑	❑	❑	❑ Age_____
Sister (# of _____)	❑	❑	❑	❑	❑	❑	❑	❑ Age_____

Please check the correct box for each item below. ❑ Past (more than one year ago); ❑ Current (less than one year ago).

GENERAL SYSTEMS

Past Current

- ❑ ❑ Memory Loss
- ❑ ❑ Chills
- ❑ ❑ Convulsions
- ❑ ❑ Dizziness
- ❑ ❑ Fainting
- ❑ ❑ Fatigue (General/Muscular)
- ❑ ❑ Fever
- ❑ ❑ Headache
- ❑ ❑ Loss of Sleep
- ❑ ❑ Hernia
- ❑ ❑ Anxiety
- ❑ ❑ Mood Changes
- ❑ ❑ Irritability

GASTRO-INTESTINAL

Past Current

- ❑ ❑ Poor Appetite
- ❑ ❑ Excessive Hunger/Thirst
- ❑ ❑ Heartburn
- ❑ ❑ Belching or Gas
- ❑ ❑ Nausea
- ❑ ❑ Vomiting
- ❑ ❑ Ulcers
- ❑ ❑ Intestinal Problems
- ❑ ❑ Poor Digestion
- ❑ ❑ Constipation
- ❑ ❑ Diarrhea
- ❑ ❑ Hemorrhoids

CARDIO-VASCULAR

Past Current

- ❑ ❑ High/Low Blood Pressure
- ❑ ❑ Angina
- ❑ ❑ Poor Circulation
- ❑ ❑ Light Headed (Positional)
- ❑ ❑ Rapid Heartbeat
- ❑ ❑ Slow/Shortness of Breath
- ❑ ❑ Chest Pain
- ❑ ❑ Strokes
- ❑ ❑ Heart Attack
- ❑ ❑ Swelling Ankles
- ❑ ❑ Varicose Veins

SKIN

Past Current

- ❑ ❑ Tattoo/Piercings
- ❑ ❑ Moles
- ❑ ❑ Boils
- ❑ ❑ Bruising Easily
- ❑ ❑ Dryness
- ❑ ❑ Eczema/Psoriasis
- ❑ ❑ Hives
- ❑ ❑ Itching
- ❑ ❑ Sensitive Skin
- ❑ ❑ Skin Eruptions
- ❑ ❑ Rashes
- ❑ ❑ Sweating

SPINE

Past Current

- ❑ ❑ Jaw Pain/Click (TMJ) R / L
- ❑ ❑ Neck Pain/Stiffness R / L
- ❑ ❑ Upper Back Pain R / L
- ❑ ❑ Mid Back Pain R / L
- ❑ ❑ Lower Back Pain R / L
- ❑ ❑ Numbness, Tingling or Pain in Buttocks, Legs, Thighs, Feet, Toes R / L
- ❑ ❑ Numbness, Tingling or Pain in Arms, Hands, or Fingers R / L
- ❑ ❑ Difficulty w/ Excessive (standing, walking, sitting, riding, bending, lifting, twisting or household chores)
- ❑ ❑ Foot Trouble
- ❑ ❑ Spinal Curvature
- ❑ ❑ Joint Pain
- ❑ ❑ Muscle Twitching
- ❑ ❑ Broken Bones
- ❑ ❑ Fractures

EYE/EAR/NOSE/THROAT

Past Current

- ❑ ❑ Glasses/Contact Lenses
- ❑ ❑ Pain in Eyes
- ❑ ❑ Light Sensitive
- ❑ ❑ Blurred/Double Vision
- ❑ ❑ Deafness
- ❑ ❑ Ear Ache/Infections
- ❑ ❑ Ear Discharges
- ❑ ❑ Ear Ringing
- ❑ ❑ Frequent Colds/Flu
- ❑ ❑ Hoarseness
- ❑ ❑ Sore Throats
- ❑ ❑ Goiter
- ❑ ❑ Tonsillitis
- ❑ ❑ Nasal Obstruction
- ❑ ❑ Nose Bleeds
- ❑ ❑ Sinusitis
- ❑ ❑ Hay Fever

RESPIRATORY

Past Current

- ❑ ❑ Allergy
- ❑ ❑ Asthma/Wheezing
- ❑ ❑ Difficulty Breathing
- ❑ ❑ Chronic Cough
- ❑ ❑ Bronchitis
- ❑ ❑ Spitting Blood
- ❑ ❑ Spitting Phlegm
- ❑ ❑ Chest Pain

GENITO-URINARY

- ❑ ❑ Bed Wetting
- ❑ ❑ Frequent Urination
- ❑ ❑ Inability to Control Urine
- ❑ ❑ Painfull Urination
- ❑ ❑ Blood in Urine
- ❑ ❑ Kidney Infection
- ❑ ❑ Bladder Infection
- ❑ ❑ Prostate Problems
- ❑ ❑ Impotence

WOMEN ONLY

Past Current

- ❑ ❑ Menstral Cramps
- ❑ ❑ PMS
- ❑ ❑ Vaginal Discharge
- ❑ ❑ Excessive Flow
- ❑ ❑ Hot Flashes
- ❑ ❑ Irregular Cycle
- ❑ ❑ Miscarriage
- ❑ ❑ Painful Periods
- ❑ ❑ Breast Problems
- ❑ ❑ Pregnant

Last Pap ____/____/_____

MISCELLANEOUS

- ❑ ❑ Unexplained Weight Loss/Gain
- ❑ ❑ Recent Infections/Night Sweats
- ❑ ❑ Night Pain
- ❑ ❑ Loss of Bowel/Bladder Function
- ❑ ❑ Pain Wakes You From Sleep
- ❑ ❑ Numbing/Tingling in <u>BOTH</u> Arms and/or Legs

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- ❑ Restless Leg Syndrome
- ❑ Pneumonia
- ❑ Rheumatic Fever
- ❑ Polio
- ❑ Tuberculosis
- ❑ Whooping Cough
- ❑ Anemia
- ❑ Measles
- ❑ Mumps
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Liver/Gall Bladder
- ❑ Heart Disease
- ❑ Cancer
- ❑ Thyroid
- ❑ Alcoholism
- ❑ Venereal Disease
- ❑ Arthritis Type?_____
- ❑ Epilepsy
- ❑ Mental Illness
- ❑ Eczema
- ❑ HIV Positive
- ❑ Other _____

(Additional space if needed)

List all Surgeries, Falls, Accidents, and Injuries (even those you thought were no big deal) and dates if known:

_____

_____

_____

Have you ever had X-rays taken? ❑ Yes ❑ No When?_____ By Whom?_____

For what ailments were these X-rays made?_____

Who is your current primary care Doctor?_____

May we contact them regarding your status/progress? ❑ Yes ❑ No

List all Drugs you are taking (include prescription and over the counter medications such as birth control, aspirin, heart pills, laxatives, antacids, cold tablets, etc.)

Type	Purpose	Dosage
_____	_____	
_____	_____	
_____	_____	
_____	_____	

ACTIVITIES OF DAILY LIVING (ADL's)

1. Type of mattress (describe)_____ How old?_____
2. Sleeping position? ❑ Side ❑ Stomach ❑ Back
3. Type of pillow? ❑ Foam ❑ Feather ❑ Other _____ How many?_____
4. Average hours of sleep?_____
5. Do you sit on a recliner chair? ❑ Always ❑ Often ❑ Never
6. Do you wear orthotics/heel lifts? ❑ Yes ❑ No If yes, were the impressions taken sitting or standing? _____
7. Do you sit on your wallet? ❑ Yes ❑ No
8. Define your stress level (use1-10 scale, 10 being the most stressful). _____ work _____ home

I hereby attest that the above information and health history I have provided is complete and accurate. I understand the importance of providing a truthful health history in order to assist the doctor in providing the best chiropractic care possible.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any undisclosed medical information.

Patient's/Guardian's Signature _____ Date _____

(Additional space if needed)