Seebacher Family Chiropractic Center- 1385 Old Freeport Rd., Pittsburgh, PA 15238 412-449-1000

Date________________

PATIENT HISTORY FORM

Name______________________________________ **Sex** M F Social Security #______________________

Address__________________________ **City**_______________________ **State**____________ **Zip**_______

Home#(_______)_______________ Work#________________ Cell#___________________________

Date of Birth______________ **Age**_________ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Email address__________________________ Would you like to receive our e-mail newsletter? ☐ Yes ☐ No

Referred by_________________________ Employer/Occupation_______________________________

Have you ever received Chiropractic Care? ☐ Yes ☐ No If yes, when? _______________By whom?________________

Primary reasons for seeking chiropractic care:

Chief Complaint: ______________________________________

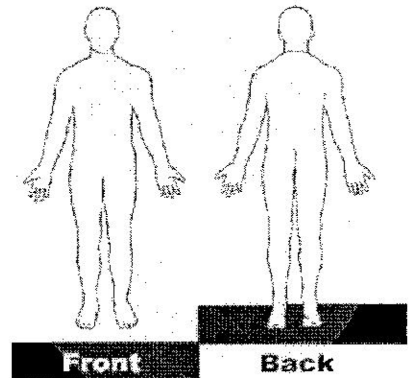
Secondary Complaint: __________________________________

Complaint Began when and how? ____________________________

CIRCLE the quality of the complaint/pain: dull aching sharp
shooting burning throbbing deep nagging other ______________

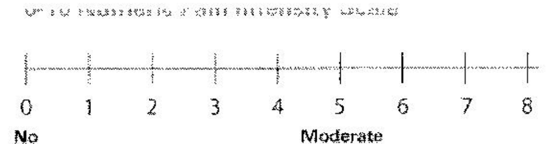
Does this complaint/pain radiate or travel (shoot) to any areas of your body? __________
Where? ___________________________

Do you have any numbness or tingling in your body?
Where? ___________________



Mark the areas of pain above

How frequent is complaint present, how long does it last? ______________



Does anything aggravate the complaint? ______________________
____

Does anything make the complaint better? ____________________
____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: ______________________________

PAST HEALTH HISTORY

1. Previous illnesses you've had in your life: ______________________________
2. Previous injury or trauma:_________________________

Have you ever broken any bones? Which? ____________________

MEDICATION:

Medication (s) and Reason for taking

____

____

LIST ANY ALLERGIES:

____

Females/ Pregnancies and outcomes:

Please check one: ☐ **Pregnant** ☐ **Not Pregnant**
Pregnancies / Date of Delivery:

____
____
____
____
____

What was the date of the beginning of your last menstrual period? ______________

LIST ANY SURGERY (IES):
Date and type of Surgery

______________ ______________ ______________

______________ ______________ ______________

FAMILY HEALTH HISTORY:

Associated health problems of relatives:

____

____

DEATHS IN THE FAMILY:

Cause of parents or siblings death and age at death

____

____

SOCIAL AND OCCUPATIONAL HISTORY:

Level of Education: O high school O some college O college graduate O post graduate studies

Job description: ______________________________

Work schedule: ______________________________

Recreational activities: ______________________________

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): ______________________________

____

Additional Comments:

____

____

____

Insurance Coverage ☐ **Yes** ☐ **No**

Name of Insurance: ______________________________

Member ID # ______________________________

Group# ______________________________

Provider Phone Number (on back) ______________________________

Contact Information (In-case of an emergency, who can we contact):

Name ______________________________

Address, City, State, Zip ______________________________

Phone# ______________ **Relationship to Patient** ______________________________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Parent or Guardian Signature ______________________________ **Date** ______________
***If under the age of 18 years**

Patient Signature ______________________________ **Date** ______________