# PATIENT HISTORY

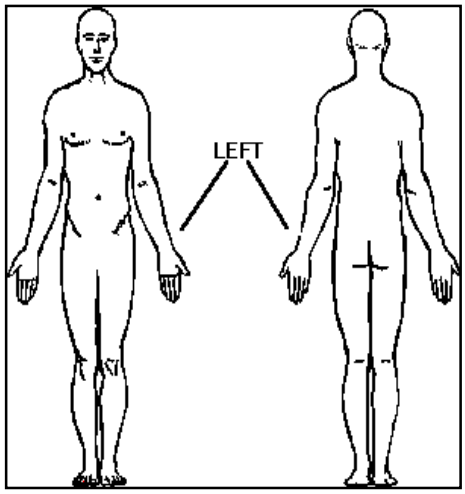
## PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____ Sex: ____ SSN: _____
Address: _____ City: _____ State: ____ Zip: _____
Phones: Home: _____ Work: _____ Cell: _____ Email: _____
Occupation (include types of activity):_____
Race: ☐American Indian or Alaskan ☐Asian ☐Black or African American ☐Hawaiian or Pacific Islander ☐White ☐Other ☐Declined
Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic ☐Declined / Primary Language: _____
Do you have insurance?_____ Insurance Carrier:_____ Marital Status: ☐S ☐M ☐D ☐W ☐Sep
In Case of Emergency Contact: _____ Relationship: _____ Phone: _____
Whom may we thank for referring you? _____

## PRIMARY REASON FOR VISIT

Describe what you are seeking our help on: _____
Is it due to an injury? ☐ Yes ☐ No, If Yes: ☐On Job ☐ Auto Accident. Date of Accident: _____ ☐ Other: _____
I am having: ☐ No Pain ☐ Mild pain ☐ Moderate pain ☐ Severe pain → PAIN LEVEL - ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
My pain feels: ☐ Dull ☐ Sharp / Knife-Like ☐ Aching ☐ Deep ☐ Surface
☐ Burning ☐ Pins & Needles ☐ Tingling ☐ Numbness ☐ Cramping

***Mark areas of discomfort:***




My symptoms started: When:_____ ☐ Immediately ☐ Gradually
My symptoms are: ☐ Getting worse ☐ Constant ☐ Getting better ☐ Comes and goes
During a 24 hour day, how often is it noticeable? _____
When during the day is it ...WORSE?_____...BETTER? _____
I've had this problem before and the last time was: _____
My pain radiates (SHOOTS) to: _____
My pain/radiation increases with: ☐ Coughing ☐ Sneezing ☐ Bowel Movement
My pain / symptom(s) **improve(s)** with:
☐ Rest ☐ Lying ☐ Sitting ☐ Standing ☐ Walking ☐ Heat ☐ Ice
☐ Nothing Other:_____
My pain / symptom(s) **worsen(s)** with:
☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Twisting ☐ Walking
☐ Kneeling ☐ Lying ☐ Pushing ☐ Pulling ☐ Climbing ☐ Gripping
☐ Reaching above shoulder level ☐Nothing ☐ Other _____
In general, my pain / symptom is worse when ☐ moving about ☐ not moving
My pain / symptom is interfering with: ☐ Work ☐ Sleep ☐ Daily Routine
What other doctors have you seen for this condition? Give type of treatment and dates: _____
Cont: _____
What do you think the problem is? _____
What do you want the Doctor to do for you? _____
What else about this condition would you like the doctor to know? _____

## HEALTH HISTORY

***Circle any condition you are currently experiencing or have experienced in the past: Mark "C" for current and "P" for past.***

| | | | | | |
|---|---|---|---|---|---|
| Fainting | Blackouts | Seizures | Memory Problems | Tremors | Balance Difficulty |
| Chest Pains | Rapid Heartbeat | Irregular Heartbeat | Difficulty Breathing | Cold Hands / Feet | Swelling Ankles/Leg |
| Vertigo / Dizziness | Hearing Loss | Ringing in Ears | Changing Voice | Difficulty Swallowin | Loss of Smell |
| Nausea / Vomiting | Diarrhea | Constipation | Rectal Bleeding | Bowel Incontinence | Liver / Gallbladder |
| Producing Cough | Asthma | Wheezing | Tuberculosis | Emphysema | Pneumonia / Pleurisy |
| Skin Rash | Skin Ulcers | Dry Skin | Itchy Skin | Bug Bites | Hair / Nail Changes |
| Eye Pain | Blurry Vision | Double Vision | Spots in Vision | Dry Eyes | Excessive Tearing |
| Weak Urine Flow | Frequent Urination | Bladder Incontinence | Dribble | Sexual Dysfunction | Urinary Urgency |
| Excessive Fever | Airborne Allergies | Food Allergies | Weight Gain / Loss | Hypoglycemia | Hyperglycemia |
| Legs Cramps | Muscle Pain | Joint Pain | Muscle Spasms | Weakness | Muscle Twitching |
| Night Sweats | Excessive Thirst | Excessive Hunger | Heat/Cold Intolerance | Currently Pregnant | |
| Anemia | Easy Bruising | | | | |

## HEALTH HISTORY (Continued)

***Check all conditions you currently experience or conditions you have been previously diagnosed with:***

| | | | | | |
|---|---|---|---|---|---|
| ☐ Blow to Skull | ☐ Osteoporosis | ☐ Spinal Cord Injury | ☐ Arthritis | ☐ Arteriosclerosis | ☐ Mental Disorder |
| ☐ Heart Attack | ☐ Bursitis | ☐ Varicose Veins | ☐ High Blood Pressure | ☐ Low Blood Pressure | ☐ Small Pox |
| ☐ Diabetes | ☐ Brucellosis | ☐ Alcoholism | ☐ Typhoid Fever | ☐ Ulcers | ☐ Whooping Cough |
| ☐ Stroke | ☐ Hepatitis | ☐ Polio | ☐ Epilepsy | ☐ Venereal Infection | ☐ Eczema |
| ☐ Diphtheria | ☐ Appendicitis | ☐ Goiter | ☐ Malaria | ☐ Rheumatic Fever | ☐ Cancer _____ |
| ☐ Measles | ☐ Scarlet Fever | ☐ Influenza | ☐ Multiple Sclerosis | ☐ Mumps | ☐ Connective Tissue Disorder |
| ☐ Autoimmune | ☐ HIV | ☐ Other: _____ | | | |

## MEDICAL AND SURGICAL HISTORY

List all surgeries (Type, approximate date): _____

Cont: _____

List any accidents you have been in: _____

List all broken bones (& approx. date): _____

List all joints dislocated (& approx. date): _____

Have you been knocked unconscious? _____ When? _____ For how long? _____

Have you had X-rays, MRIs or CTs taken before? _____ When? _____ By whom? _____

Why?_____

Have you received chiropractic care before?_____ When? _____

## MEDICATIONS AND ALLERGIES

***List all medications*** *(prescribed and over-the-counter) you are currently taking, including birth control medications:*

_____ _____ _____

_____ _____ _____

_____ _____ _____

List known allergies: _____

## FAMILY HISTORY

I have _____ older sibling(s) and _____ younger sibling(s). I have _____ living children, ages _____

List major health conditions of blood relatives (i.e. grandparents, parents, siblings, children, aunts, uncles):

| Family Member | Health Problem(s) | Age of Death (if applicable) |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## SOCIAL HISTORY

| ***Do you now use / do*** | ***No*** | ***Yes*** | ***Explain:*** |
|---|---|---|---|
| Alcohol | ☐ | ☐ | How many drinks per day? _____ |
| Drugs (recreational) | ☐ | ☐ | Type _____ |
| Tobacco | ☐ | ☐ | How Long have you smoked? _____ Date you quit smoking _____ |
| Coffee | ☐ | ☐ | How many cups per day? _____ |
| Soft drinks | ☐ | ☐ | How many drinks per day? _____ ☐ Regular ☐ Sugar Free |
| Exercise | ☐ | ☐ | How many times per week? _____ ☐ Mild ☐ Moderate ☐ Severe Intensity |
| Sleep soundly all night | ☐ | ☐ | How many hours per night? _____ |

Stress Work: ☐ Hi ☐ Med ☐ Lo Home: ☐ Hi ☐ Med ☐ Lo

Describe appetite ☐ Normal ☐ Poor ☐ Always Hungry

Dominant hand: ☐ Left ☐ Right ☐ Either

## OTHER CONCERNS

List any other conditions that you are interested in having the doctor check:

1. _____
2. _____

## AUTHORIZATION

*I understand incorrect information, including omissions, on this document may lead to an incorrect diagnosis and treatment plan. I hereby authorize the doctor to conduct an examination regarding my complaints. I understand that this case is not accepted by the doctor until the doctor has decided it is appropriate for chiropractic care and until the patient/guardian has consented to treatment.*

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