Tulsa Chiropractic Rehab

New Patient History

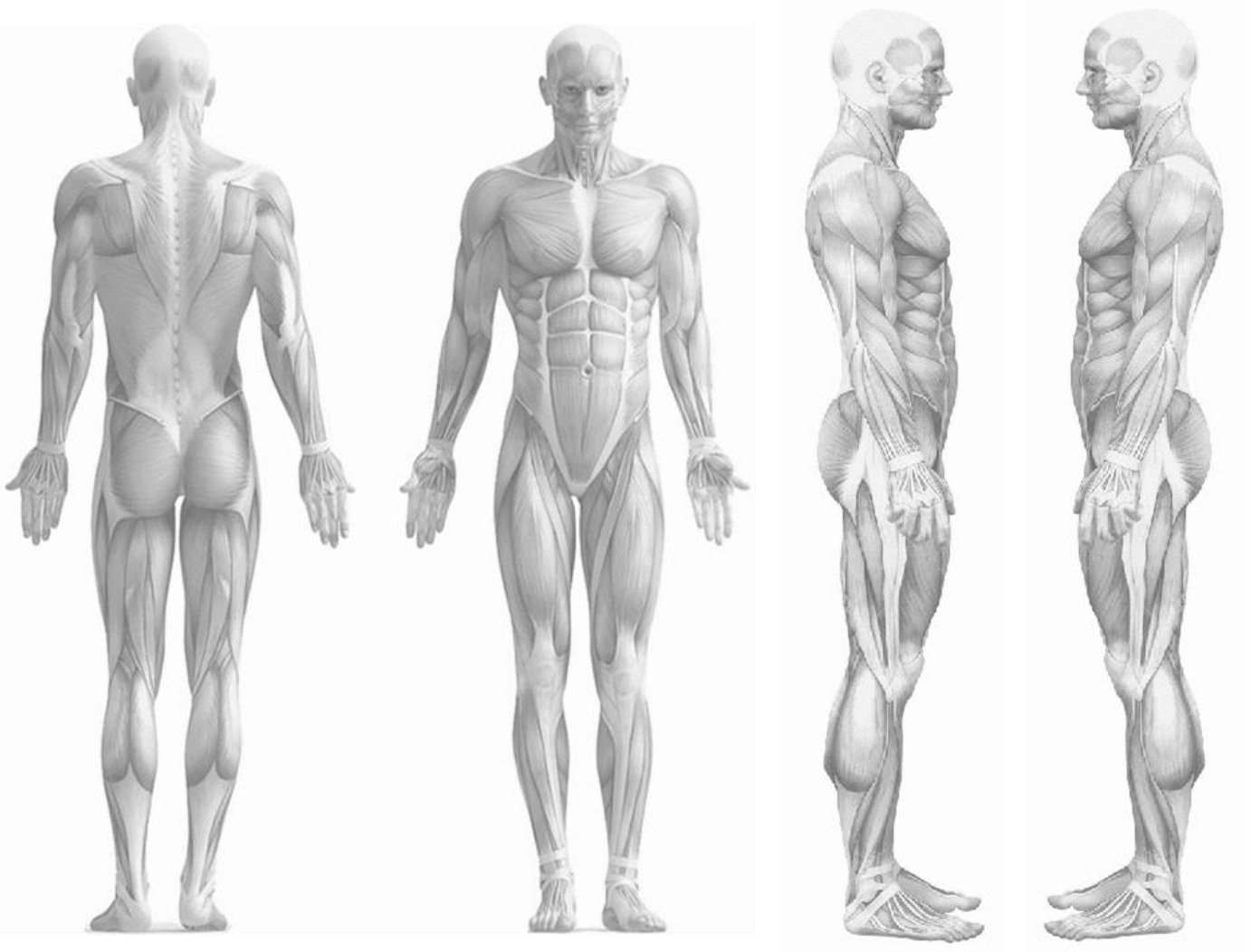
Patient Data

				Date:	/ /		
First name:		Last name:		SSN			
Address		City		State		Zip	
DOB	/ /	Age		Email			
Cellphone		Home		Work			
Occupation		Employer					
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed						
Spouse's name		How did you hear about us?					
Emergency Contact Name		Phone		Relation			

Pain Diagram

Please use the following letters to indicate type and location of the symptoms you currently are experiencing

O= Throbbing **T**= Tight **V**= Sharp ***=Shooting **A**= Ache **E=**Electric
N= Numbness **S=** Stabbing **B**= Burning ///= Pins & Needles **X=** Other_____



Complaints

Please separate your complaints and describe them individually below.
List the most severe complaint first

Example			
Complaint#1	**Description / Location**	**When did it start?**	**What caused it?**
Neck and shoulder pain.	Both sides of my neck ache. Especially the base of my neck and tops of shoulders	Last Monday	Working on computer. Bad Posture.

Complaint # 1	Description / Location	When did it start?	What caused it?

Complaint # 2	Description / Location	When did it start?	What caused it?

Complaint # 3	Description / Location	When did it start?	What caused it?

Other Complaints	Description / Location	When did it start?	What caused it?

What Kind of care are you seeking? Mark all that apply

Kind of Plan	Type of treatment
☐ "Tune ups" As needed	☐ Manipulation/Adjustment
☐ Regular Maintenance Care (1-2 x month)	☐ Therapies (EMS, Ultrasound, Traction)
☐ Plan of Care (1-3 x week)	☐ Rehab (Targeted Stretches & Exercises)
☐ Doctor Suggestion for your case	☐ Massage

Current Medical History

Do you have a primary care provider or family doctor? ☐ Yes ☐ No
Name: _____ Clinic: _____
Address: _____ Phone: _____

Are you seeing any other doctors? ☐ Yes ☐ No
Name:_____ Clinic: _____ Address:_____
Specialty: _____ Reason: _____

Name:_____ Clinic: _____ Address:_____
Specialty: _____ Reason: _____

Are your Doctors aware of your current complaints/conditions? ☐ Yes ☐ No
May we discuss your complaints/conditions with your doctors? ☐ Yes ☐ No

Do you have any current diagnosis or conditions related to your current complaint? ☐ Yes ☐ No
Please Explain: _____

Do you have any congenital conditions? ☐ Yes ☐ No _____

Do you have any allergies to medications, materials, or environmental allergies? ☐ Yes ☐ No
_____
_____

What medications, or supplements are you taking?

Meds / Supplements	Purpose	Start Date

Past Medical History

When was your last physical exam? Date_____ Doctor _____

Have you had any surgeries or hospitalizations? If so, please describe when and what for:

Date	Reason

Have you ever been in a car wreck? If so, when and please describe (if described above, skip)
_____
Have you ever had a sports injury? If so, when and please describe (if described above, skip)
_____
Describe any other past injuries or accidents or any other relevant info you wish us to know…
_____
_____

Family History

Please review the below listed disease and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. If deceased, list cause of death.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	GRAND FATHER – GRAND MOTHER (Paternal) Age [ ] -Age [ ]	GRAND FATHER – GRAND MOTHER (Maternal) Age [ ]-Age[ ]	BROTHER(S) Age [ ], Age [ ]	SISTER(S) Age [ ]-Age[ ]
Arthritis	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Asthma-Hay Fever	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Back Trouble	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Bursitis	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Cancer	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Constipation	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Diabetes	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Disc Problem	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Emphysema	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Epilepsy	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Headaches	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
High Blood Pressure	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Insomnia	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Kidney Trouble	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Liver Trouble	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Migraine	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Nervousness	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Neuritis	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Neuralgia	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Pinched Nerve	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Scoliosis	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Sinus Trouble	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Stomach Trouble	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Other (Specify)	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Deceased	☐	☐	☐ - ☐	☐ - ☐	☐ - ☐	☐ - ☐
Cause of Death						

Social History

Employment/ Work (Job/School/ Play)
□Working full-time □Working part-time □Regular duty □Light duty

□Student □Retired □Unemployed □Disabled □Other _____

Cultural Religious
Are there any customs or religious beliefs or wishes that might affect your care? □Yes □No
Please explain _____

Social / Health Habits

- **Nicotine**: □Yes □No □Past
  Type: □Cigarettes □Chew □Vape □Other_____
- **Recreational Drugs**: □Yes □No □Past
  Type/Description_____
- **Alcohol:** □Yes □No □Past
  How many drinks per day?_____ per week?_____
  Do you suffer from alcoholism? □Yes □No □Past
- **Caffeine:** □Yes □No
  How much caffeinated beverages do you drink per day? _____
  □Coffee □Energy Drinks □Soda □Other:_____
- **Exercise:** □Yes □No
  Type:_____
  How many days per week? _____ how many minutes per day? _____
- **Sleep:**
  Hours per night? _____
  Quality: □Great □Good □Okay □Poor □Terrible
- **Stress:**
  □None □Low □Mild □Moderate □High □Extreme

General Health Status
Please rate your health: □Excellent □Good □Fair □Poor

Living Environment
With whom do you live?
□Alone □Spouse □Spouse and Children □Spouse and Others □Children □Roommate(s)
□Other Relatives □Group Setting □Personal Care Attendant □Other _____

Language
Primary Language _____ Other Languages Spoken _____
Do you need a translator for a language? □Yes □No _____

Learning Barriers
□None □Vision □Hearing □Other _____

Review of Systems

Past or **C**urrent or **N**one

	P	C
Past Conditions --> Mark **Left Box**	☑	☐
Current Conditions --> Mark **Rigth Box**	☐	☑
None in category --> Mark **last Box**	☑	

General:
- ☐ ☐ ◦ Recent Weight Change
- ☐ ☐ ◦ Fever
- ☐ ☐ ◦Fatigue
- ☐ ◦None in this Category

Muskuloskeletal
- ☐ ☐ ◦ Low back Pain
- ☐ ☐ ◦ Mid Back Pain
- ☐ ☐ ◦ Neck Pain
- ☐ ☐ ◦ Arm Problems_____
- ☐ ☐ ◦ Leg Problems _____
- ☐ ☐ ◦ Painful Joints
- ☐ ☐ ◦ Stiff/Swollen Joints
- ☐ ☐ ◦ Sore/Weak Muscles or Joints
- ☐ ☐ ◦ Muscle Spasms/Cramps
- ☐ ☐ ◦ Broken Bones _____
- ☐ ☐ ◦ Other_____
- ☐ ◦ None in this Category

Neurological
- ☐ ☐ ◦ Numbness or Tingling Sensations
- ☐ ☐ ◦ Loss of Feeling
- ☐ ☐ ◦ Dizziness or Light Headed
- ☐ ☐ ◦ Frequent or Recurrent Headaches
- ☐ ☐ ◦ Convulsions or seizures
- ☐ ☐ ◦ Tremors
- ☐ ☐ ◦ Stroke
- ☐ ☐ ◦ Have you ever had a head injury?
- ☐ ☐ ◦ Ever been in a auto accident?
- ☐ ☐ ◦ Other_____
- ☐ ◦ None in this Category

Mind/Stress
- ☐ ☐ ◦ Nervousness
- ☐ ☐ ◦ Depression
- ☐ ☐ ◦ Sleep Problems
- ☐ ☐ ◦ Memory Loss or Confusion
- ☐ ☐ ◦ Other_____
- ☐ ◦ None in this Category

Genitourinary
- ☐ ☐ ◦ Sexual Difficulty
- ☐ ☐ ◦ Kidney Stones
- ☐ ☐ ◦ Burning/Painful Urination
- ☐ ☐ ◦ Change in force/strain w/ urination
- ☐ ☐ ◦ Frequent Urination
- ☐ ☐ ◦ Blood in Urine
- ☐ ☐ ◦ Incontinence or Bed Wetting
- ☐ ☐ ◦ Other_____
- ☐ ◦ None in this Category

Gastrointestinal
- ☐ ☐ ◦ Loss of Appetite
- ☐ ☐ ◦ Blood in Stool
- ☐ ☐ ◦ Change in Bowel Movements
- ☐ ☐ ◦ Painful Bowel Movements
- ☐ ☐ ◦ Nausea or Vomiting
- ☐ ☐ ◦ Abdominal Pain
- ☐ ☐ ◦ Frequent Diarrhea
- ☐ ☐ ◦ Constipation
- ☐ ☐ ◦ Other_____
- ☐ ◦ None in this Category

Cardiovascular and Heart
- ☐ ☐ ◦ Chest Pains
- ☐ ☐ ◦ Rapid or Heartbeet Chages
- ☐ ☐ ◦ Blood Pressure Problems
- ☐ ☐ ◦ Swelling of Hands, Ankles or Feet
- ☐ ☐ ◦ Heart Problems
- ☐ ☐ ◦ Other_____
- ☐ ◦ None in this Category

Respiratory
- ☐ ☐ ◦ Difficulty Breathing
- ☐ ☐ ◦ Presistent Cough
- ☐ ☐ ◦ Coughing Blood
- ☐ ☐ ◦ Asthma or Wheezing
- ☐ ☐ ◦ Lung Problems
- ☐ ☐ ◦ Other_____
- ☐ ◦None in this Category

Eyes and Vision
- ☐ ☐ ◦ Wear Contacts/Glasses
- ☐ ☐ ◦ Blurred or Double Vision
- ☐ ☐ ◦ Glaucoma
- ☐ ☐ ◦ Eye Disease or Injury
- ☐ ☐ ◦ Other_____
- ☐ ◦ None in this Category

Ears, Nose and Throat
- ☐ ☐ ◦ Bleeding gums/ mouth sores
- ☐ ☐ ◦ Bad Breath or bad taste
- ☐ ☐ ◦ Dental Problems
- ☐ ☐ ◦ Swollen throat or voice change
- ☐ ☐ ◦ Swollen glands in neck
- ☐ ☐ ◦ Ringing in the ears
- ☐ ☐ ◦ Ear - Ache/Ringing/Drainage
- ☐ ☐ ◦ Sinus / Allergy Problems
- ☐ ☐ ◦ Nose Bleeds
- ☐ ☐ ◦ Hearing Loss
- ☐ ☐ ◦ Other_____
- ☐ ◦ None in this Category

Endocrine, Hematologic and Lymphatic
- ☐ ☐ ◦ Thyroid Problems
- ☐ ☐ ◦ Diabetes
- ☐ ☐ ◦ Excessive thirst or urination
- ☐ ☐ ◦ Cold Extremities
- ☐ ☐ ◦ Heat or Cold intolerance
- ☐ ☐ ◦ Change in hat or glove size
- ☐ ☐ ◦ Dry Skin
- ☐ ☐ ◦ Glandular or hormone problem
- ☐ ☐ ◦ Swollen Glands
- ☐ ☐ ◦ Anemia
- ☐ ☐ ◦ Easily Bruise or Bleed
- ☐ ☐ ◦ Phlebitis
- ☐ ☐ ◦ Transfusion
- ☐ ☐ ◦ Immune System Disorder
- ☐ ☐ ◦ Other_____
- ☐ ◦ None in this Category

Skin and Breast
- ☐ ☐ ◦ Rash or Itching
- ☐ ☐ ◦ Change in Skin Color
- ☐ ☐ ◦ Change in hair or nails
- ☐ ☐ ◦ Non-healing sores
- ☐ ☐ ◦ Change of appearance of a mole
- ☐ ☐ ◦ Breast Pain
- ☐ ☐ ◦ Breast Lump
- ☐ ☐ ◦ Breast Discharge
- ☐ ☐ ◦ Other_____
- ☐ ◦ None in this Category

Women Only
- ☐ ☐ ◦ Infertility
- ☐ ☐ ◦ Painful or Irregular Periods
- ☐ ☐ ◦ Vaginal Discharge
- ☐ ☐ ◦ Other_____
- ☐ ◦ None in this Category

Are you Pregnant?

☐ Yes - due date_____/_____/_____

☐ No - Last menstrual period

____/____/_____

Pregnancies with Outcome & Date:

_____

_____

_____

_____

_____

_____

Comments:_____

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 to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature:_____ Date:_____