Patient History (Please Print)

Date:______________________

Name: ____ Email: _
____

Phone: (Home) _____________________ (Mobile) _________________________ (Work) _____________________

Address: ____ City: _____________________ Zip: _______________

_ Birth Date: ____/____/______ ☐ Male _ ☐ Female _ Spouse/Parent Name: _______________________

# of Children: _____________ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Are you Pregnant? ☐ YES ☐ NO Due Date:_______________

Occupation/Employer: _________________________________ Social Security #: _______________ ________

How were you referred to our office? ____

If from the internet, name of search engine and key words used: ________________________________

Have you ever had Chiropractic Care before? ________________ If yes, when? ___________________________

List your chief complaints in order of severity; Check all those that describe your condition:

Complaint 1: ______________________________________ For How Long? ________________________________

What originally caused this problem? ____

Feels Like:

☐ Sharp _ ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling _

☐ Burning ☐ Other: ___________________________ _

Bothers Me: _

☐ Constant (100%) _ ☐ Frequent (50%-75%) _ ☐ Occasional (25%-50%) _ ☐ Intermittent (1%-25%) _

It Has Been: _

☐ Getting Worse ☐ Staying Same ☐ Getting Better _

Pain Scale: (0=No Pain - 10=Severe Pain) _

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 _

During The Day It Is:

☐ Worse in the AM ☐ Stays the same throughout the day ☐ Worse in the PM _

The Following Increases Pain: _

☐ Moving ☐ Sitting ☐ Lifting ☐ Bending ☐ Walking ☐ Laying Down ☐ Other: _________________ _

The Following Decreases Pain:

☐ Moving ☐ Sitting ☐ Lifting ☐ Bending ☐ Walking ☐ Laying Down ☐ Other: _________________ _

Does The Pain Travel/Radiate? : _

☐ Yes ☐ No If yes, where____________________________ to ________________________________

Complaint 2: ______________________________________ For How Long? ________________________________

What originally caused this problem? ____

Feels Like:

☐ Sharp _ ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling _

☐ Burning ☐ Other: _ ___________________________

Bothers Me: _

☐ Constant (100%) _ ☐ Frequent (50%-75%) _ ☐ Intermittent (25%-50%) _ ☐ Occasional (1%-25%) _

It Has Been: _

☐ Getting Worse _ ☐ Staying Same _ ☐ Getting Better _

Pain Scale: (0=No Pain - 10=Severe Pain) _

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

During The Day It Is:

☐ Worse in the AM ☐ Stays the same throughout the day ☐ Worse in the PM _

The Following Increases Pain: _

☐ Moving ☐ Sitting ☐ Lifting ☐ Bending ☐ Walking ☐ Laying Down ☐ Other: _________________ _

The Following Decreases Pain:

☐ Moving ☐ Sitting ☐ Lifting ☐ Bending ☐ Walking ☐ Laying Down ☐ Other: _________________ _

Does The Pain Travel/Radiate? : _

☐_Yes ☐ No If yes, where_____________________________ to _________________________________

Complaint 3: ____ For How Long? ___________________________________

What originally caused this problem? ____

Feels Like:_

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling_

☐_Burning ☐ Other: ____________________________

Bothers Me:_

☐_Constant (100%)_ ☐_Frequent (50%-75%)_ ☐ Intermittent (25%-50%)_ ☐_Occasional (1%-25%)_

It Has Been:_

☐_Getting Worse ☐ Staying Same ☐ Getting Better_

Pain Scale: (0=No Pain - 10=Sever Pain)_

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10_

During The Day It Is:_

☐_Worse in the AM ☐ Stays the same throughout the day ☐ Worse in the PM_

The Following Increases Pain:_

☐_Moving ☐ Sitting ☐ Lifting ☐ Bending ☐ Walking ☐ Laying Down ☐ Other: __________________

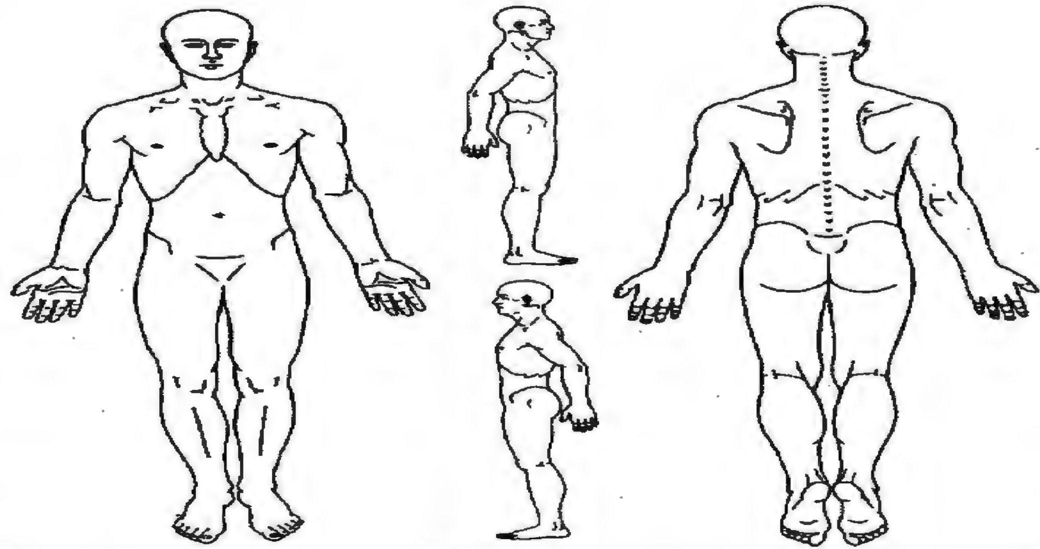
The Following Decreases Pain:_

☐ Moving ☐ Sitting ☐ Lifting ☐ Bending ☐ Walking ☐ Laying Down ☐ Other: _________________

Does The Pain Travel/Radiate? :_

☐_Yes ☐ No_ If yes, where____________________________ to_________________________________

Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels. Include all affected areas.



Does your condition interfere with your:

Work	☐ NO	☐ MILD	☐ MODERATE_	☐ SEVERE_
Sleep	☐ NO	☐ MILD	☐ MODERATE_	☐ SEVERE_
Daily Routine	☐ NO	☐ MILD_	☐ MODERATE_	☐ SEVERE_
Recreation	☐ NO	☐ MILD_	☐ MODERATE_	☐ SEVERE_

Does your condition interfere with any of the following:

☐ Computer Use	☐_ Cleaning_	☐ Shopping
☐ Sports	☐_ Cooking_	☐ Gardening
☐_ Reading_	☐ _Watching Kids_	☐ School
☐ Exercise_	☐_ Yard Work_	☐ Self Care
☐ Vacuuming_	☐ _Driving_	☐ Other: ______________
☐_ Social Life_	☐ _Relationship_	

Health History (Check if you have now or have had in the past:)		
☐ Abdominal Aortic Aneurysm	☐ Erectile Dysfunction	☐ Mumps
☐ AIDS/HIV	☐ Eye Troubles	☐ Osteoporosis
☐ Alcoholism	☐ Fractures	☐ Pacemaker
☐ Allergy Shots	☐ Glaucoma	☐ Parkinson's
☐ Anemia	☐ Goiter	☐ Pneumonia
☐ Anorexia	☐ Gonorrhea	☐ Prostate Problems
☐ Appendicitis	☐ Gout	☐ Psychiatric Care
☐ Bleeding Disorders	☐ Heart Disease	☐ Rheumatoid Arthritis
☐ Bulimia	☐ Heart Issues	☐ Stroke
☐ Buzzing/Ringing in Ears	☐ Hepatitis	☐ Suicide Attempt
☐ Cancer	☐ Hernia	☐ Swollen Ankles
☐ Cataracts	☐ Herniated Disc	☐ Throat Conditions
☐ Chemical Dependency	☐ Herpes	☐ Thyroid Conditions
☐ Chicken Pox	☐ High Cholesterol	☐ Tuberculosis
☐ Chronic Bronchitis	☐ Hypertension/ HBP	☐ Tumors/Growths
☐ Chronic Fatigue	☐ Indigestion	☐ Typhoid Fever
☐ Chronic Tonsillitis	☐ Kidney Disease	☐ Ulcers
☐ Constipation	☐ Kidney Stones	☐ Unexplained Memory Loss
☐ Coronary Artery Disease	☐ Liver Disease	☐ Unexplained Weight Loss
☐ Diabetes	☐ Measles	☐ Unexplained Weight Gain
☐ Diarrhea	☐ Menstrual Problems	☐ UTI
☐ Digestive Problems	☐ Mid Back Pain	☐ Vaginal Infections
☐ Dysmenorrhea	☐ Miscarriage	☐ Venereal Disease
☐ Eczema	☐ Mononucleosis	☐ Whooping Cough
☐ Emphysema	☐ Multiple Sclerosis	☐ Other:_______________

Family History (please list all known conditions/illnesses that may apply):

Mother: ____ Father: ____

Grandparents: ____ Siblings: ____

Other known familial conditions: ____

List other doctors consulted for condition:

1: ____ 2: ____

3: ____ 4: ____

List of Current Medications/Supplements:

Concerns:

We've found that these are the common concerns people like you have. We want to make sure you are comfortable before we start care. Add any others that are relevant and put an X by your top 3.

Is it going to hurt?	I don't want to be cracked
Do I have to come forever?	Is it addictive?
Are the X-rays dangerous?	Is it safe for children?
Is it expensive?	What if insurance does not cover chiropractic?
What do I do if chiropractic does not work?	Can this be fixed?

Strengths:

Strong habits are key to health. It helps us take care of you if we have an idea of how you take care of your body. Add any others that are relevant and put an X by your top 3.

Stretch 3-5 times a week	Exercise 3-5 times a week
Drink ½ my body weight of ounces of water	Take supplements for health
Have a positive attitude	Sleep 6-8 hours a night
Drink or eat something green everyday	Get maintenance chiropractic 2-4 times a year
Do activities to minimize stress regularly	Non-smoker

Goals:

We want to make sure you get lasting relief and enjoy maximum functional improvement. Add any others that are relevant and put an X by your top 3.

Sleep through the night	Exercise again
Continue working/get back to work	Avoid future flare ups
Play with kids/grandkids normally	Get off pain medications
Be ready for an upcoming event	Have a better attitude
Have some moments of relief	Sit/stand comfortably for an extended period

List of Previous Hospital Stays/Surgeries: (What and When?)

List of Any Childhood Traumas / Accidents / Falls / Auto Injuries: (What happened and When?)

Is there anything else you think we should know about or that you would like to discuss? (Explain):

Are you interested in Nutritional Services? (i.e, Nutritional Consultation, Hair Mineral Analysis, or Nutrient Analysis)

☐ YES ☐ NO

Patient's Signature: ______________________________________ Date: _________________________

Notice: Not all patients require x-rays to determine or verify a diagnosis, type and length of care.
If your examination warrants x-ray analysis, the following office policy prevails:
All first visit charges are to be paid when services are rendered.
The fee paid for x-rays is for analysis only.
The film itself is the property of this office and cannot be released.

*** If you have insurance please give your card to the front desk staff***