

Patient Health History

Date _____ I.D. # _____

Name: _____ Age: _____ Date of Birth: _____ Sex: MF
 Address: _____ City: _____ State: _____ Zip: _____
 Phone (Home): _____ (Work): _____ Marital Status: S M D W Number of Children: _____
 Occupation: _____ Social Security Number: _____
 Employer: _____ Driver's License Number: _____
 Spouse's Name: _____ Spouse's Age: _____ Spouse's Date of Birth: _____
 Spouse's Occupation: _____ Spouse's Social Security Number: _____
 Spouse's Employer: _____ Spouse's Phone (Work): _____
 Insured's Name: _____ Insured's Phone: _____ Insured's Date of Birth: _____
 Insurance Company: _____ Spouse's Insurance Company: _____
 How did you hear about this office: _____ Referred by: _____
 Past Chiropractic Care: Yes No When? _____ Doctor's Name: _____ Results: _____

Are your present problems due to an injury? Yes No On Job Auto Accident Personal Injury Other: _____
 Has the accident been reported? Yes No To Employer Auto Carrier Other: _____
 Are you now or have you ever been disabled? (Service or Work)? Yes No When? _____
 Have you retained an attorney? Yes No Name & Address: _____

What is your current work status?
Full time, no restrictions Full time, restrictions Full time Homemaker Full time student
Part time, no restrictions Part time, restrictions Retired Unemployed
Off work due to restrictions Other _____

Restrictions:
 Off work: Yes No Previously From: _____ to _____
 Light duty: Yes No Previously (If yes, what are/were your restrictions?) _____
 Do/did you require outside help at home?
Yes No (If yes, what help do/did you need?) _____

List any accidents or falls and dates: Auto: _____ Recreation: _____
Sports: _____ Work Related: _____ Other: _____
 List any broken bones (fractures) or dislocations: _____
 Ever on crutches? Yes No Why? _____
 Were you ever knocked unconscious? Yes No (If yes, please explain): _____
 Have you ever had X-rays taken? Yes No When? _____ By Whom? _____
 For what ailments were these X-rays made? _____
 Do you wear orthotics or heel lifts? Yes No Fitted by whom? _____ When? _____
 Do you suffer from any condition other than that for which you are now consulting us? Yes No _____
 Are you presently taking any medication, prescription, over-the-counter, home remedies, vitamins, minerals, etc?
 (Please list) _____

OPERATIONS AND PROCEDURES

I have never had any operations or surgeries

DATE		DATE		DATE	
_____	Vaccinations	_____	Spinal Taps/Injections	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
Other _____					

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. Never Previously Presently

<input type="checkbox"/> Never <input type="checkbox"/> Previously <input type="checkbox"/> Presently	<input type="checkbox"/> Never <input type="checkbox"/> Previously <input type="checkbox"/> Presently	<input type="checkbox"/> Never <input type="checkbox"/> Previously <input type="checkbox"/> Presently	<input type="checkbox"/> Never <input type="checkbox"/> Previously <input type="checkbox"/> Presently
GENERAL SYMPTOMS		GASTRO-INTESTINAL	
<input type="checkbox"/> Allergy(What) _____ <input type="checkbox"/> Bronchitis <input type="checkbox"/> Chills (Constant) <input type="checkbox"/> Convulsions <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Headache <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Night Sweats <input type="checkbox"/> Numbness or Pain in arms/legs/hands <input type="checkbox"/> Wheezing		<input type="checkbox"/> Belching or Gas <input type="checkbox"/> Colon Trouble <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Gall Bladder Trouble <input type="checkbox"/> Hemorrhoids (piles) <input type="checkbox"/> Jaundice <input type="checkbox"/> Liver Trouble <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach Pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting Blood <input type="checkbox"/> Heart Burn <input type="checkbox"/> Bloody Stools <input type="checkbox"/> Acid Reflux <input type="checkbox"/> Irritable Bowel	
MUSCLES & JOINTS		CARDIO-VASCULAR	
<input type="checkbox"/> Backache <input type="checkbox"/> Foot Trouble <input type="checkbox"/> Hernia <input type="checkbox"/> Pain Between Shoulders <input type="checkbox"/> Painful Tail Bone <input type="checkbox"/> Stiff Neck <input type="checkbox"/> Spinal Curvature <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Tremors <input type="checkbox"/> Twitching		<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Heart Trouble <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Rapid Heart <input type="checkbox"/> Slow Heart <input type="checkbox"/> Strokes <input type="checkbox"/> Swelling Ankles <input type="checkbox"/> Varicose Veins	
		EYE/EAR NOSE/THROAT	
		<input type="checkbox"/> Asthma <input type="checkbox"/> Deafness <input type="checkbox"/> Earache <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Ear Noises <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Hay Fever <input type="checkbox"/> Nasal Obstruction <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Pain in Eyes <input type="checkbox"/> Poor Vision <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Sinusitis <input type="checkbox"/> Sore Throats <input type="checkbox"/> Tonsillitis	
		SKIN OR ALLERGIES	
		<input type="checkbox"/> Bruising Easily <input type="checkbox"/> Dryness <input type="checkbox"/> Eczema <input type="checkbox"/> Hives or Allergy <input type="checkbox"/> Itching <input type="checkbox"/> Sensitive Skin <input type="checkbox"/> Skin Eruptions	
		RESPIRATORY	
		<input type="checkbox"/> Chest Pain <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Spitting Blood <input type="checkbox"/> Spitting Phlegm	
		GENITO-URINARY	
		<input type="checkbox"/> Bed Wetting <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Inability to Control Urine <input type="checkbox"/> Kidney Infection <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Painful Urination <input type="checkbox"/> Prostate Trouble	
		FOR FEMALES ONLY	
		<input type="checkbox"/> Cramps <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Irregular Cycle <input type="checkbox"/> Painful Periods <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant at this Time _____ Last Pap Date _____ Last Menstrual Cycle	

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Measles
<input type="checkbox"/> Goiter	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Mumps	<input type="checkbox"/> Influenza	<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Polio	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Lumbago	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Eczema	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Cancer	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> HIV Positive

HABITS

Smoking Packs/day: _____
 Drinking Alcohol: (Cups/day) _____
 Coffee Cups/Day: _____
 Soft Drink Bottles or Cans/Day: _____
 Water Cups/Day: _____

EXERCISE

None
 Moderate Mother _____
 Daily Father _____
 Type: _____ Brother(s), # of _____
 _____ Sister(s), # of _____

FAMILY HISTORY

Diabetes	Kidney	Cancer	Back
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider **will/will not** prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor to examine and treat my condition as he/she 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 to the Doctor for imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

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

#0060699

**CURRENT COMPLAINT HISTORY
(PATIENT)**

Patient Name: _____

Date: _____

Please check all boxes that apply to your condition and fill in the spaces that describe your present complaint(s). Also, the information you provide concerning past symptoms will help in assisting the doctor to better understand your present complaints and total health picture.

Please list your present complaint(s) and mark your level of pain today for each complaint – If you have more than one area of complaint, list them in order of most severe to least severe.

1. _____ **Duration – (How Long / Date):** _____ **# of Previous Episodes:** _____
(Please circle one.) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)
2. _____ **Duration – (How Long / Date):** _____ **# of Previous Episodes:** _____
(Please circle one.) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)
3. _____ **Duration – (How Long / Date):** _____ **# of Previous Episodes:** _____
(Please circle one.) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Has anyone treated you for this episode? Yes No If yes, by whom? _____

How did your **symptoms begin?**

- Immediately after a specific incident After multiple Incidents Gradually developed over time Other _____

What makes your **symptoms better?**

- Nothing Lying down Standing Sitting Movement/Exercise Other _____

What makes your **symptoms worse?**

- Nothing Lying down Standing Sitting Movement/Exercise Other _____

Are your **symptoms?**

- Decreasing Increasing
 Not Changing Other _____

Description of pain or symptoms:

- | | |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Ache | <input type="checkbox"/> Numb |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Other _____ |

Does your pain **move** or **radiate**?

- Yes No Where _____

Check the best and worse **times of the day** for your **pain**:

- | | |
|--------------------------------------|--------------------------------------|
| Worse | Best |
| <input type="checkbox"/> First Awake | <input type="checkbox"/> First Awake |
| <input type="checkbox"/> Morning | <input type="checkbox"/> Morning |
| <input type="checkbox"/> Afternoon | <input type="checkbox"/> Afternoon |
| <input type="checkbox"/> Evening | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Nighttime | <input type="checkbox"/> Nighttime |
| <input type="checkbox"/> Other | <input type="checkbox"/> Other |

Frequency of pain or symptoms:

- | | |
|---------------------------------------|---------------|
| <input type="checkbox"/> Constant | (76 – 100%) |
| <input type="checkbox"/> Frequent | (51 – 75%) |
| <input type="checkbox"/> Occasional | (26 – 50%) |
| <input type="checkbox"/> Intermittent | (25% or less) |

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: A = ACHE B = BURNING N = NUMBNESS P = PINS & NEEDLES
S = STABBING X = STIFFNESS T = THROBBING O = OTHER

How many days out of **an average week** are you in **pain**? (Please circle one.) 1 2 3 4 5 6 7

How much time during the **day** are you in **pain**?

- less than 1 hour 1 to 6 hours 6 to 12 hours 12 to 18 hours 18 to 24 hours 24 hours

Patient's/Guardian's Signature: _____

Date: _____