

PATIENT HISTORY

Name: _____ Date: _____

Home Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Marital Status: M S W D

School Address (if student): _____ School Phone: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security # _____ Occupation: _____

Employer: _____ Work Phone: _____

Spouse: _____ Employer: _____

E-mail Address: _____ Would you be interested in receiving e-mail
about Chiropractic Care? Yes No

Method of payment: Self Pay Insurance _____

Medicare Medicaid

Workers' Comp Auto Insurance

How were you referred to our office? _____

What is your major complaint? _____

Other complaints: _____

MEDICAL HISTORY (Indicate with and "X" for personal history, "F" for family history)

<input type="checkbox"/> Allergies/Asthma	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Mental disorders
<input type="checkbox"/> Oral contraceptive use	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Regular use of blood thinner	<input type="checkbox"/> Regular us high blood pressure medication
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Smoking (packs/day____)
<input type="checkbox"/> Regular use of caffeine	<input type="checkbox"/> Shingles	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid disease	
<input type="checkbox"/> Venereal disease	<input type="checkbox"/> Whiplash injury	

Present weight: _____ Any weight loss or gain in past year? _____

Last physical exam _____ Dr. _____

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees due for services rendered to me will be immediately due and payable.

Patient's signature (if minor, parent's signature)

Date

Please complete other side of sheet also.

IMPORTANT: Please check (X) all present symptoms.

Head:

- Headache
 - sinus (allergy)
 - entire head
 - back of head
 - forehead
 - temples
 - migraine
- Head feels heavy
- Loss of memory
- Light-headedness
- Fainting
- Light bothers eyes
- Blurred vision
- Double vision
- Loss of vision
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Buzzing in ears

Neck:

- Pain in neck
- Neck pain with movement
 - Forward
 - Backward
 - Turn to left
 - Turn to right
 - Bend to left
 - Bend to right
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

Shoulders:

- Pain in shoulder joint (R—L)
- Pain across shoulders
- Bursitis (R—L)
- Arthritis (R—L)
- Can't raise arm
 - Above shoulder level
 - Over head
- Tension in shoulders
- Pinched nerve in shoulder (R—L)
- Muscle spasms in shoulders

Chest:

- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Dimpled or orange peel breast
- Irregular heartbeat

Arms & Hands:

- Pain in upper arms
- Pain in elbow
- Movement aggravated
- Tennis elbow
- Pain in forearm
- Pain in hands
- Pain in fingers
- Sensation of pins & needles in arms
- Sensation of pins & needles in fingers
- Numbness in arms (R—L)
- Numbness in fingers (R—L)
- Fingers go to sleep
- Hands cold
- Swollen joints in fingers
- Sore joints in fingers
- Arthritis in fingers
- Loss of grip strength

Mid-Back:

- Mid-back pain
- Location _____
- Pain between should blades
- Sharp stabbing
- Dull Ache
- Pain from front to back
- Muscle spasms
- Pain in kidney area

Abdomen:

- Nervous stomach
- Foods can't eat _____
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

Low Back:

- Low back pain
 - Upper lumbar
 - Lower lumbar
 - Sacroiliac
- Low back pain is worse when
 - working
 - lifting
 - stooping
 - standing
 - sitting
 - bending
 - coughing
 - lying down (sleeping)
 - walking
- Pain relieves when _____
- Slipped disk
- Low back feels out of place
- Muscle spasms
- Arthritis

Hips, Legs & Feet:

- Pain in buttocks (R—L)
- Pain in hip joint (R—L)
- Pain down leg (R—L)
- Pain down both legs
- Knee pain
 - Inside
 - Outside
- Leg cramps
- Cramps in feet (R—L)
- Pins & needles in legs (R—L)
- Numbness of leg (R—L)
- Numbness of feet (R—L)
- Numbness of toes
- feet feel cold
- Swollen ankles (R—L)
- Swollen feet (R—L)

Women Only:

- Menstrual pain _____ (where)
- Cramping
- Irregularity
- Cycle _____ days
- Birth control _____ (type)
- Hysterectomy
- Genital cancer _____
- Discharge _____
- Menopause _____
- Tumors _____
- Abortions _____
- Are you or do you think you might be pregnant?

Men Only:

- Urinary frequency
- Difficulty in starting
- Night urination
- Prostate pain/swelling

General:

- Nervousness
- Irritable
- Fatigue
- Generally feel run down
- Normal sleep _____
- Loss of sleep _____ hrs/night
- Coffee _____ cups/day
- Tea _____ cups/day
- Other _____
- Hypoglycemia

Remarks:
