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: _____ 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%) □ 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 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 _____

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

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=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: _____

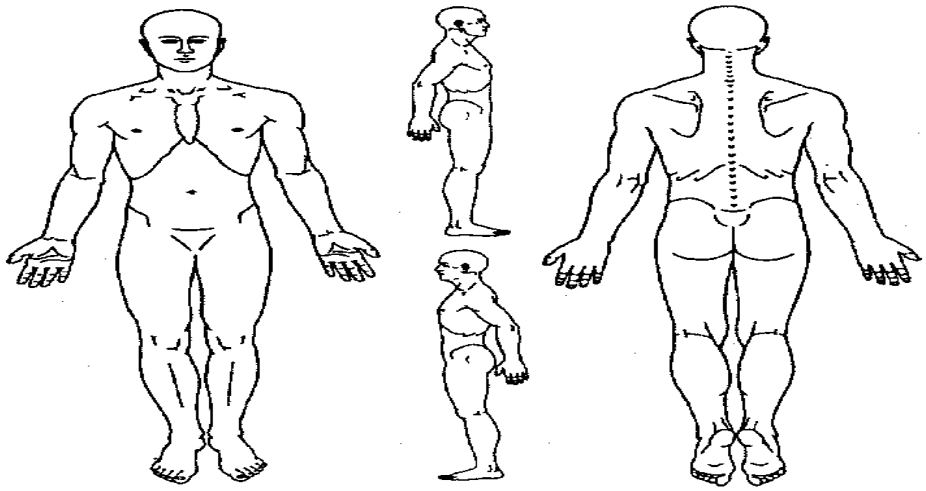
The Following Decreases Pain:

□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____

Does The Pain Travel/Radiate? :

□ Yes □ No If yes, where_____ to _____

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 you:

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	

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

Health History (Check if you have ever had any of the following:)		
□ Abdominal Aortic Aneurysm	□ Emphysema	□ Multiple Sclerosis
□ Acid Reflux	□ Epilepsy	□ Mumps
□ AIDS/HIV	□ Erectile Dysfunction	□ Neck Pain
□ Alcoholism	□ Eye Troubles	□ Osteoporosis
□ Allergies	□ Fractures	□ Pacemaker
□ Allergy Shots	□ Glaucoma	□ Parkinson's
□ Anemia	□ Goiter	□ Pinched Nerve
□ Anorexia	□ Gonorrhea	□ Pneumonia
□ Anxiety	□ Gout	□ Prostate Problems
□ Appendicitis	□ Headaches	□ Psychiatric Care
□ Arthritis	□ Heart Disease	□ Rheumatoid Arthritis
□ Asthma	□ Heart Issues	□ Shortness of Breath
□ Bleeding Disorders	□ Hepatitis	□ Stroke
□ Bulimia	□ Hernia	□ Suicide Attempt
□ Burning Feet	□ Herniated Disc	□ Swollen Ankles
□ Buzzing/Ringing in Ears	□ Herpes	□ Throat Conditions
□ Cancer	□ High Cholesterol	□ Thyroid Conditions
□ Cataracts	□ Hip Pain	□ Tuberculosis
□ Chemical Dependency	□ Hypertension/ HBP	□ Tumors/Growths
□ Chicken Pox	□ Indigestion	□ Typhoid Fever
□ Chronic Bronchitis	□ Infertility	□ Ulcers
□ Chronic Fatigue	□ Insomnia	□ Unexplained Memory Loss
□ Chronic Sinus Infections	□ Kidney Disease	□ Unexplained Weight Loss
□ Chronic Tonsillitis	□ Kidney Stones	□ Unexplained Weight Gain
□ Constipation	□ Leg Pain	□ Upper Back Pain
□ Coronary Artery Disease	□ Liver Disease	□ UTI
□ Depression	□ Low Back Pain	□ Vaginal Infections
□ Diabetes	□ Measles	□ Venereal Disease
□ Diarrhea	□ Menstrual Problems	□ Vertigo
□ Difficulty Swallowing	□ Mid Back Pain	□ Whooping Cough
□ Digestive Problems	□ Migraines	□ Other:_____
□ Dysmenorrhea	□ Miscarriage	
□ Eczema	□ Mononucleosis	

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

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:
_____
_____
_____

List of Previous Hospital Stays/Surgeries:
_____
_____
_____

List of Any Childhood Traumas / Past Accidents / Falls / Auto Injuries:
_____
_____

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:

1. 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 the front desk your card *****