Patient History

Name: Date:

Mailing Address:

number and street city state zip code

Email Address:

Primary Telephone: Secondary Telephone:

Date of Birth: Age: Gender: M F

mm dd yyyy

Marital Status: M S W D Number of Children:

Emergency Contact: Telephone:

Your Occupation: Employer:

Work Telephone:

Whom may we thank for referring you to this office?

Person responsible for account:

What is your major complaint?

Date major complaint began:

mm dd yyyy

Is this condition becoming progressively worse?

Other complaints?

List surgical operations with dates:

Are you taking medication? If so, please list name(s) and describe purpose:

Do you use non-prescription drugs? If so, please list the name(s):

Patient Signature: Doctor's Initials:

Have you previously received chiropractic care? _____

Have you seen other doctors for this condition? _____ Diagnosis? _____

Doctor's Name: _____

Indicate tests performed: _____ _____ _____ _____

Xrays urinalysis blood other

Treatment: _____

Medication: _____

Physiotherapy: _____

Results: _____

Length of time under care: _____

Did you miss work? _____ If so, for how long? _____

Did you return to the same job? _____ If not, please give the reason: _____

Do you exercise? _____ If so, please describe your regimen: _____

_____

Do you smoke or use smokeless tobacco? _____ If yes, describe: _____

Do you consume alcohol? _____ If yes, how much and how often? _____

Do you drink water? _____ If yes, how much per day? _____

Is there anything else you would like us to know to help facilitate your healing process? _____

_____

Please check 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/buzzing in ears
- ☐ other:

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/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 (R L)
- ☐ tension in shoulders
- ☐ pinched nerve in shoulder (R L)
- ☐ muscle spasms in shoulders

ARMS & HANDS:
- ☐ pain in upper arm
- ☐ pain in elbow
- ☐ movement aggravated
- ☐ tennis elbow
- ☐ pain in forearm
- ☐ pain in hands
- ☐ pain in fingers
- ☐ sensation of pins & needles
  - ☐ in fingers ☐ in arms
- ☐ numbness in arms (R L)
  - ☐ numbness in fingers
- ☐ 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 shoulder blades
- ☐ sharp stabbing
- ☐ dull ache
- ☐ pain from front to back
- ☐ muscle spasms
- ☐ pain in kidney area

CHEST:
- ☐ chest pain
- ☐ shortness of breath
- ☐ pain around ribs
- ☐ breast pain
- ☐ irregular heartbeat

ABDOMEN:
- ☐ nervous stomach
- ☐ foods can't eat _____
- ☐ nausea
- ☐ gas
- ☐ constipation
- ☐ diarrhea
- ☐ hemorrhoids

LOW BACK:
- ☐ low back pain
  - ☐ upper lumbar
  - ☐ lower lumbar
  - ☐ sacroilliac
- ☐ low back pain is worse when:
  - ☐ walking
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
  - ☐ lying down (sleeping)
- ☐ 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)
  - ☐ of feet (R L)
  - ☐ of toes (R L)
- ☐ feet feel cold
- ☐ swollen ankles (R L)
- ☐ swollen feet (R L)

WOMEN ONLY:
- ☐ menstrual pain
- ☐ cramping
- ☐ irregular cycle
- ☐ hysterectomy (when) _____
- ☐ are you or do you think you are pregnant? _____

MEN ONLY:
- ☐ urinary frequency
- ☐ difficulty in starting
- ☐ night urination
- ☐ prostate pain/swelling

GENERAL:
- ☐ nervousness
- ☐ irritability
- ☐ depression
- ☐ fatigue
- ☐ generally feel run-down
- ☐ loss of sleep (hrs/night) _____
- ☐ loss of weight _____ lbs
- ☐ gain weight _____ lbs
- ☐ coffee _____cups/day
- ☐ tea _____cups/day
- ☐ cigarettes _____pack/day
- ☐ diabetes
- ☐ hypoglycemia
- ☐ other

Other Information:

I have read and completed the information on pages 1 & 2 of this form and it is true and correct.

I understand and agree that I am financially responsible for all services rendered to me. If this office files an insurance claim on my behalf I understand and agree that I will be responsible for payment of any deductible and/or co-pay amounts that apply as outlined by my insurance company's policy and plan.

Patient Signature: **Date:**

Doctor Initials: **Date:**