PATIENT HISTORY

Date: ___________________

Name: ______________________________________ Referred By? __________________________________

Address: ____ City: ______________ State: _____ Zip: __________

Home Phone: ____________________ Work Phone: _____________________ Cell Phone:__________________

Date of Birth: _______________ Age: ______ Sex: F / M Marital Status: _______ # of Children: ______

Occupation: __________________________ Employer: ____

Social Security # (for insurance purposes only): ______________________________

PLEASE FILL IN THE APPROPRIATE SPACES (All information you provide is kept confidential):

Major Complaint(s): ____

____

How long have you had this condition? ________________________________ Date Began? __________________

Have you lost work days? YES ☐, NO ☐, How many? ____

Have you had this similar condition before? YES ☐, NO ☐, When? ___________________________________

Was the injury related to: Work Accident ☐, Auto Accident ☐, Other ☐:________________________________

When did you last see a chiropractor? _______________________ Dr.:____________________________________

Why did you see this chiropractor? ___________________________________ Were you helped? _____________

What spinal maintenance programs were you given to follow to maximize the future stability of your spine?

____

Did you follow it? _________________ If not, why? ____

Why are you changing chiropractors? ____

PAST (*O*) OR PRESENT (*X*) CONDITIONS (Please mark with *O* or *X*; if nothing relates to you, leave blank):

A) ___ Fractured Bones
___ Auto Accidents
(a) ____ 0-1 years ago
(b) ____ 1-5 years ago
(c) ____ More than 5 year ago
___ Other Accidents/ Falls/ Slips
___ Knocked Unconscious
___ Back Curvature
___ Mental or Emotional Disorders
___ Arthritis
___ Diabetes
___ Swollen or Painful Joints
___ Convulsion/ Epilepsy
___ Skin Problems
___ Itching
___ Bruise Easily
___ Cancer
___ Frequent Colds/ Flu

B) ___ Nervous
___ Tension
___ Depressed
___ Irritable
___ Anemia
___ Excess Sweating
___ Tremors
___ Eyes Sensitive to light
___ Allergy
___ Sinus Problems
___ Light-Headed Upon Rising
___ Under Stress
___ Crave Sweets or Salt
___ Eating Disorders

C) ___ Trouble Sleeping
___ Trouble Concentrating
___ Loss of Memory
___ Learning Disability
___ Mistake sidedness (R from L)
___ Stutter
___ Dyslexia
___ Mood Changes
___ Lose Temper Easily

D) ___ Headaches/ Migraines
___ Neck Pain or Stiffness (R, L)
___ Numbness, tingling or pain in arms, hands, fingers (R, L)
___ Jaw pain or click (TMJ)(R, L)
___ Head seems too heavy
___ Head & Shoulders feel tired

___ Difficulty in excessive (standing, walking, sitting, bending, lifting, twisting, household duties, etc.)
___ Shoulder Pain (R, L)
___ Dizziness
___ Ringing in ears (R, L)
___ Hearing Loss (R, L)
___ Fainting
___ Loss of Balance
___ Blurred or double vision (R, L)
___ Upper back pain or stiffness (R, L)
___ Mid Back pain or stiffness (R, L)
___ Lower back or stiffness (R, L)
___ Numbness, tingling or pain in buttocks, thighs, legs, feet, toes (R, L)
___ Pain with coughing, sneezing or strain at stools
___ Hip Pain (R, L)

___ Foot Trouble (R, L)

E) ___ Chest Pain
___ Asthma
___ Lung Problems
___ Difficult Breathing
___ Wheezing
___ Heart Problems
___ Stroke
___ High or low blood pressure
___ Varicose Veins
___ Liver Trouble
___ Gall Bladder Trouble

F) ___ Digestive Problems
___ Excessive Gas
___ Belching/ bloating after meals
___ Heartburn
___ Ulcers
___ Diarrhea/ Constipation
___ Colon Trouble
___ Hemorrhoids
___ Prostate Problems
___ Impotence

G) ___ Kidney Trouble
___ Kidney Stones
___ Frequent Urination
___ Discharge
___ Menstrual problems/ PMS
___ Menopausal problems
___ Breast Lumps, soreness, discharge
___ Pregnant (currently)
___ Bedwetting
___ Ear infections
___ Hepatitis
___ Venereal Disease (VD)
___ AIDS/ HIV

WHAT IS YOUR HEALTH PHILOSOPHY? (What should you do to be healthy?): ___________________________

____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

______ Temporary Relief (Help the symptom but not fix the cause of the problem).

______ Maximum Correction (Correct the cause of the problem for maximum stability in the future).

WHY DID YOU COME INTO OUR OFFICE & WHAT ARE YOUR EXPECTATIONS OF US: ______________

____

1. What are your favorite hobbies or activities to do now? ______________________________________
2. Are your current problems affecting these hobbies or activities? _______________________________

ON A SCALE OF 1-10 (10 being the most, and 1 being the least)…

_______ How committed are you at being at your maximum health potential?

_______ How important is it for your family to be at their optimum health potential?

_______ How committed are you to preventing arthritis & maximizing your spinal stability?

What surgeries have you had? ____

Please list drugs you now take (prescription & non-prescription); *Use 3rd page to write more medications*:

____

Cont. of Medication/Drug List:

____

____

____

____

Name other doctors you have seen for this condition: *What was done, and for how long?*

____

____

____

____

Are you currently wearing: Heel lifts (Y / N) Arch Supports (Y / N)

Are you interested in: Weight Loss (Y / N) Anti-Aging (Y / N) Chemical-Free Cleaners (Y / N)

NOTE: PLEASE FEEL FREE TO ASK ABOUT OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RECEIVED UNLESS ARRANGEMENTS ARE MADE IN ADVANCE.
SEE "POLICY & CHIROPRACTIC CARE FEES" FORM.

YOUR PERSONAL INFORMATION & EMAIL IS NOT RELEASED TO ANYONE OR ANY COMPANY; YOUR INFORMATION IS FOR OUR RECORDS ONLY.
SEE "NOTICE OF PRIVACY" FORM.

Email Address: (You will receive monthly e-newsletters, chiropractic tips, massage discounts, etc.)

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Please sign and date below stating all information written above (provided by you, the patient) is accurate and current information:

Signature: ____ **Date:** ________________