

PATIENT HISTORY

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Birth Date _____ Sex _____ Age _____ Marital Status _____ # of Children _____
Occupation _____ Employer _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____
Social Security # _____ Referred By _____
Email _____ Spouse/Parent _____

Emergency Contact: Name _____ Phone Number _____

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

MAJOR COMPLAINT _____

How long have you had this condition? _____

Have you lost work days: [] Yes [] No How many? _____

Have you had this or similar condition before? [] Yes [] No When? _____

Was the injury related to: [] Work accident [] Auto accident?

How often do you experience your symptoms?

- [] Constantly (76-100% of the day)
[] Frequently (51-75% of the day)
[] Occasionally (26-50% of the day)
[] Intermittently (0-25% of the day)

During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, ect)

- [] Not at all [] A little of the time
[] Most of the time [] None of the time
[] Some of the time

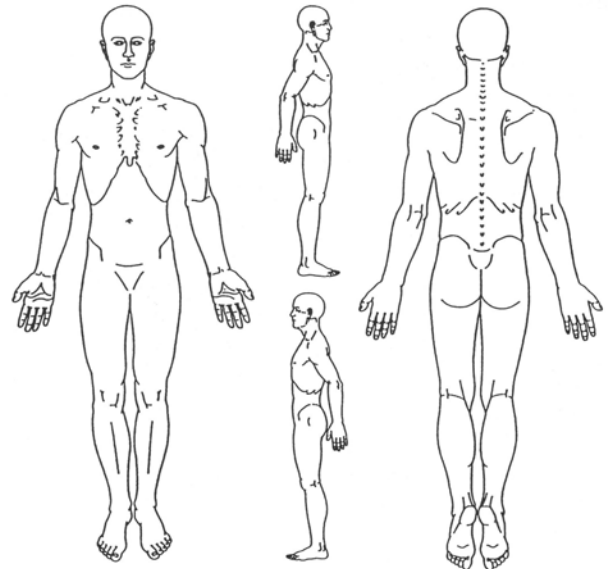
What describes the nature of your symptoms?

- [] Sharp [] Shooting
[] Dull [] Ache [] Burning
[] Numb [] Tingling

Indicate where you have pain or other symptoms.

How are your symptoms changing?

- [] Getting Better
[] Not Changing
[] Getting Worse



During the past 4 weeks:

A. Indicate the average intensity of your symptoms.

0—1—2—3—4—5—6—7—8—9—10

B: How much has pain interfered with your normal work? (Both occupation and housework)

- [] Not at all [] Quite a bit
[] A little bit [] Extremely
[] Moderately

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

Did the other doctors order any diagnostic tests or imaging? (X-Ray, CT, MRI, Ultrasound, etc)

If so please list the procedure and the date.

What surgeries have you had and when? _____

List drugs you now take (prescription and non-prescription): _____

CHIROPRACTIC HISTORY

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 maximize the future stability of your spine?

Did you follow it? ____ If not, Why? _____

Why are you changing chiropractors? _____

Are you currently wearing? Heel Lifts Arch Supports

PAST (O) OR PRESENT (X)

- A Fractured Bones Learning Disability Wheezing
- Auto Accidents Mistake sidedness (R. from L.) Heart Problems
- (a) 0-1 years ago Stutter Stroke
- (b) 1-5 years ago Dyslexia High or low blood pressure
- (c) More than 5 years Mood Changes Varicose Veins
- Other Accidents/Falls Lose Temper easily Liver Trouble
- Knocked Unconscious Headache Gall Bladder trouble
- Back Curvature Neck pain or stiff R. L. Digestive problems
- Mental or Emotional Disorders Numbness, tingling, or pain in arms, Excessive Gas
- Arthritis hands, fingers R. L. Belching/bloating after meals
- Diabetes Jaw pain or click (T.M.J.) R. L. Heartburn
- Swollen or Painful Joints Head seems to heavy Ulcers
- Convulsions/Epilepsy Head & Shoulders feel tired Diarrhea/constipation
- Skin Problems Difficulty in excessive (standing, Colon Trouble
- Itching walking, sitting, riding, bending, Hemorrhoids
- Bruise Easily lifting, twisting, household duties) Prostate problems
- Cancer Shoulder pain R. L. Impotence
- Frequent Colds/Flus Dizziness Kidney trouble
- B Nervous Ringing in ears R. L. Kidney stones
- Tension Hearing loss R. L. Frequent urination
- Depressed Fainting Discharge
- Irritable Loss of balance Menstrual problems/PMS
- Anemia Blurred or double vision R.L. Menopausal problems
- Excess Sweating Upper back pain or stiffness R. L. Breast lumps, soreness,
- Tremors Mid back pain or stiffness R. L. discharge
- Light Bothers Eyes Lower back pain or stiffness R. L. Pregnant (now)
- Allergy Numbness, tingling or pain in buttocks, Bedwetting
- Sinus Problems thighs, legs, feet, toes R. L. Ear infections
- Light Headed Upon Rising Pain with cough, sneeze or strain at stools Hepatitis
- Under stress Hip pain R. L. Venereal Disease
- Crave Sweets or Salt Foot trouble R. L. AIDS/HIV
- Eating disorders Chest pain Smoking ____Packs/Day
- C Trouble Sleeping Asthma Alcohol ____Drinks/Day
- Trouble concentrating Lung problems Recreational Drugs
- Loss of Memory Difficult Breathing Family Hx _____

PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE.

Signature _____