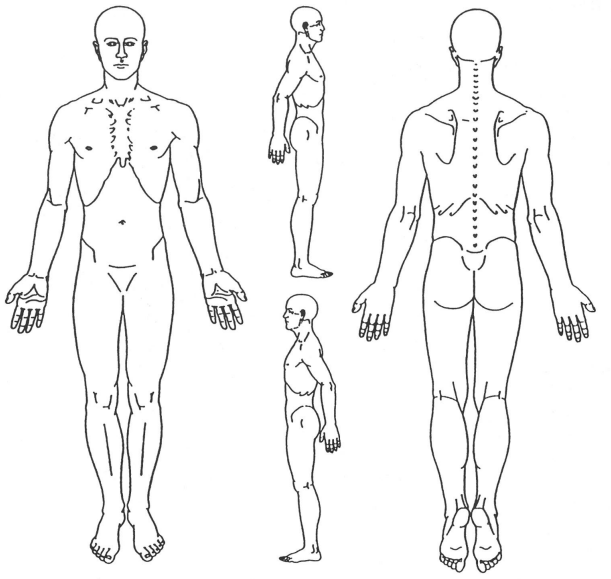
CONDITION HISTORY

Name _____ **Date** _____

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

I. On the diagram below, indicate where you hurt.



- Describe the onset of your symptoms.
  ☐ Sudden ☐ Gradual
- When did symptoms begin? _____
- What is the status of your symptoms?
  ☐ Getting better
  ☐ Getting worse
  ☐ Staying the same
- Is there any particular movement or activity that makes the pain worse? ☐ Yes ☐ No
  If yes, explain. _____
- What have you done to help your condition?
  _____
  Did it help? ☐ Yes ☐ No ☐ Temporarily

II. Rate your pain as you answer the following questions.

- How bad does it hurt on average?
  Indicate the intensity of your symptoms.
  0—1—2—3—4—5—6—7—8—9—10
- How often do you experience symptoms?
  ☐ Constantly—all the time
  ☐ Frequently—most of the time
  ☐ Intermittently—off and on
  ☐ Occasionally—once in a while
  ☐ Seldom—very little
- Describe the quality of your pain.

☐ Ache	☐ Pounding	☐ Throbbing
☐ Burning	☐ Sharp	☐ Tingling
☐ Dull	☐ Shooting	☐ Tightness
☐ Numb	☐ Tender	☐ _____

- Is there any time of day that it is worse?
  ☐ In the morning ☐ After work / exercise
  ☐ At night ☐ Other: _____
- What hobbies or activities of daily living are being affected by this condition? _____
  _____

1. Name any other doctors you have seen for this condition: what was done & for how long?
   _____
   Were diagnostic tests or imaging ordered (X-ray, CT, MRI, Ultrasound, etc) ☐ Yes ☐ No
   List the procedures & date: _____
2. Have you had this or a similar condition before? ☐ Yes ☐ No When? _____
3. Have you lost work days? ☐ Yes ☐ No How many? _____
4. Was the injury related to ☐ Work accident ☐ Auto accident?

MEDICAL HISTORY

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

CHIROPRACTIC HISTORY

When did you last see a chiropractor? _____ Dr. _____

Why did you see him/her? _____ Were you helped? ☐ Yes ☐ No

Why are you changing chiropractors?_____

Are you currently wearing? ☐ Heel Lifts ☐ Arch Supports

SURGICAL HISTORY

What surgeries have you had & when?

(i.e. gall bladder 2-28-2000)

_____ _____

_____ _____

_____ _____

_____ _____

PRESCRIPTION DRUGS

List supplements & drugs (both non-prescription & prescription), dosage, & frequency you are taking.

(i.e. ibuprofen 200 mg 4x a day, etc.)

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY (*Excluding yourself*)

Circle any conditions in your family & list the member by the condition.

- diabetes _____
- thyroid disease / goiter_____
- tuberculosis _____
- kidney disease _____
- high blood pressure _____
- heart disease _____
- cancer _____
- muscle/bone/nerve disease_____
- lung disease _____
- ulcers _____
- inflammatory arthritis _____
- seizures / stroke _____

ALLERGIES

What allergies & reactions do you have (both medical & environmental)? What was onset date?

(i.e. pollen sneezing & itchy eyes 4-1-98)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY

Smoking ☐ Yes ☐ No
_____ packs / day

Alcohol ☐ Yes ☐ No
_____ drinks / day
_____ socially only

Recreational drugs ☐ Yes ☐ No

PAST (O) OR PRESENT (X)

GENERAL
___ cancer
___ depression
___ dizziness
___ fainting
___ fever / chills
___ forgetfulness
___ goiter
___ loss of sleep
___ nervousness
___ night sweats
___ rapid weight loss / gain
___ stress
___ fatigue
___ thyroid disease

MUSCULAR / SKELETAL
___ inflammatory arthritis
___ spinal curvature
___ chronic muscle aches
___ chronic swollen joints

EAR, NOSE, & THROAT
___ earache R / L
___ ear discharge R / L
___ loss of hearing R / L
___ ringing in the ears R / L
___ blurred / double vision
___ vision flashes / halos
___ nosebleeds (frequent)
___ sinus problems
___ hoarseness

RESPIRATORY
___ chronic cough
___ coughing up blood
___ excessive phlegm
___ pneumonia
___ tuberculosis

CARDIAC
___ bleeding disorders
___ chest pain
___ high / low blood pressure
___ irregular heartbeat
___ rapid heartbeat
___ poor circulation
___ rheumatic fever
___ swelling of ankles
___ varicose veins

NEUROLOGICAL
___ dizziness
___ epilepsy / seizures
___ fainting
___ headache
___ mental disorder
___ numbness / tingling
___ tremors
___ weakness

SKIN
___ bruise easily
___ changes in moles
___ hives / rashes
___ itching
___ significant scars
___ skin cancer
___ sores which won't heal

GASTRO-INTESTINAL
___ difficulty swallowing
___ bloating
___ excessive gas
___ excessive hunger
___ excessive thirst
___ indigestion
___ nausea (frequent)
___ ulcers
___ vomiting (frequent)
___ vomiting blood
___ abdominal pain
___ appendicitis
___ black or tarry stools
___ constipation (frequent)
___ diarrhea (frequent)
___ hemorrhoids
___ hernia
___ rectal bleeding
___ gall bladder problems
___ liver problems

URINARY TRACT
___ blood in urine
___ difficulty in starting urination
___ frequent urinary tract infections
___ frequent urination
___ inability to control urination
___ painful urination
___ kidney disease
___ STD

MALE
___ breast lump
___ erectile dysfunction
___ penis discharge
___ prostate problems
___ testicular pain / swelling

FEMALE
___ breast lump
___ nipple discharge
___ hot flashes
___ abnormal Pap smear
___ bleeding between periods
___ extreme menstrual pain
___ painful intercourse
___ vaginal discharge

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

I ***request / decline*** a printed clinical summary ***via e-mail*** after every visit. **Please circle one.**
(often blank due to frequency of chiropractic care)

Signature _____ Date _____