CONFIDENTIAL PATIENT HISTORY

Name_____ Today's Date:_____ Date of Birth____/____/____ Age_____

Sex: M F Marital Status S M D W Occupation_____ Employer_____

Address_____ City_____ State____ Zip_____

Cell (_____)_____ Work (_____)_____ Home Phone (_____)_____

E-Mail_____ May we send you newsletters or office information by e-mail? Y N

May we text you appointment reminders? Y N

Spouse's Name_____ # of children _____ Your Height: _____'_____" Your Weight: _____lbs.

Emergency contact name/ #_____ Phone# (_____)_____

Primary Care Doctor Name_____ Phone# (_____)_____ May we contact them? Y N

For payment, I plan to use (please circle): Check/cash/credit IMS barter Care Credit Flex/HSA Health Insurance

Your health insurance company:_____ Phone #(_____)_____ ID#_____

Group#_____ Insured's Name (if not your own)_____ Insured's Date of Birth____/____/____

Are your present problems due to an injury? (circle) Y N Date of Injury____/_____/_____ If yes, (circle) On the Job Auto Accident

Was the accident reported to auto insurance or employer? (circle) Y N

Is the injury case still open? (circle) Y N If you have retained an attorney, list name and ph# here_____

How did you hear about our office?_____

Why did you come to the office and what are your expectations of us?_____

_____

How do you want us to handle your problem? (check) ___Temporary relief (help symptom) OR ___Maximum correction (fix the problem)

Past Chiropractic Care? (circle) Y N When?_____ Have you had spinal x-rays in the past year? (circle) Y N

List all Drugs (prescription and over the counter**)** AND Nutritional Supplements you are taking **USE BACK OF PAGE IF NECESSARY**

Name	Purpose	Dosage

List any known allergies:_____

List all Surgeries, Falls, Auto Accidents, and Injuries (regardless of how severe) and dates if known

_____

_____

HEALTH HISTORY – Please mark all that apply (past or present)

General
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Hernia
- ☐ Migraines
- ☐ Chest pain
- ☐ Heart Disease
- ☐ Light headed (positional)
- ☐ Pacemaker
- ☐ Strokes
- ☐ Kidney Disease
- ☐ Broken bones

Spine
- ☐ Herniated Discs
- ☐ Jaw Pain/Click/TMJ R / L
- ☐ Neck pain/stiffness R / L
- ☐ Mid back pain R / L
- ☐ Lower back pain R / L
- ☐ Numbness, tingling, or pain in arms, hands fingers R / L
- ☐ Shoulder pain R / L
- ☐ Elbow pain R / L
- ☐ Wrist/hand pain R / L
- ☐ Numbness, tingling, or pain in buttocks, Legs, thighs, feet, toes R / L
- ☐ Hip pain R / L
- ☐ Knee pain R / L
- ☐ Ankle/foot pain R / L

Miscellaneous
- ☐ Loss of bowel/bladder function
- ☐ Night pain
- ☐ Numb/tingling in BOTH arms and/or legs
- ☐ Pain wakes you from sleep
- ☐ Unexplained weight loss/gain

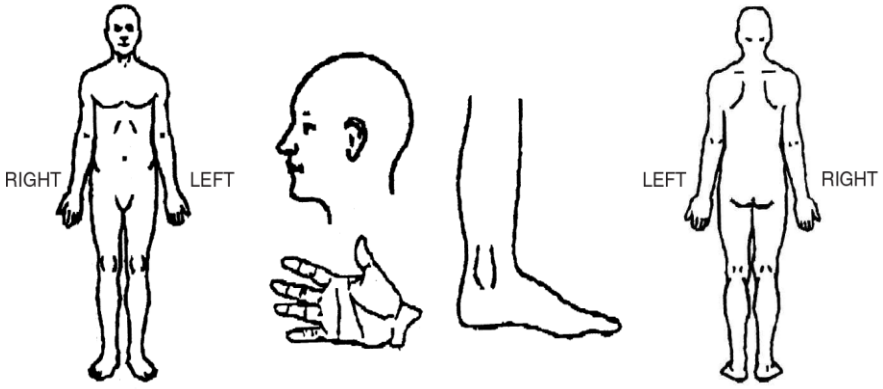
Women Only
- ☐ Breast Implants
- ☐ Pregnant
- ☐ Unsure if pregnant
- ☐ Not pregnant
- ☐ Taking birth control pills

Describe problems with any of the following systems:

Eyes:_____
Ears, nose, mouth, throat:_____
Respiratory:_____
Gastrointestinal:_____
Genitals:_____
Urinary system:_____
Skin:_____
Breast:_____
Neurological:_____
Psychiatric:_____
Endocrine:_____
Hematological/lymphatic:_____
_____
Allergic/Immunological:_____
_____

Please circle area and type of pain on the drawings using the codes listed below

N - Numbness	TH - Throbbing
P - Pain	MSP – Muscle Spasm
SH - Sharp	SHO - Shooting
T - Tingling	B - Burning
A - Ache	C - Cramps
D - Dull	SW - Swelling
S - Soreness	O - Other
ST - Stiffness	



BELOW: list your symptoms, from <u>most severe</u> to <u>mildest</u>, and include ANY and ALL areas that bother you including knees, shoulders, hands, feet, ear infections, headaches, jaw, etc.

Worst symptom:_____ What happened?_____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 When did the pain start? _____

Quality of pain (circle all that apply): sharp shooting dull ache burning stabbing stiff throbbing numbness

Does your pain radiate into arms? Y N Legs? Y N

Worse with (circle all that apply): sitting standing walking bending lifting other:_____

Better with (circle all that apply): rest ice heat stretching exercise pain relievers topical creams other:_____

Worse during (circle): morning afternoon evening during sleep

What treatment have you received for this condition (circle): medication physical therapy surgery other:_____

List any area of your life affected by this complaint (ex: work, home, kids, hobbies, etc) 1. _____

2. _____

3. _____

Symptom 2:_____ What happened?_____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 When did the pain start? _____

Quality of pain (circle all that apply): sharp shooting dull ache burning stabbing stiff throbbing numbness

Does your pain radiate into arms? Y N Legs? Y N

Worse with (circle all that apply): sitting standing walking bending lifting other:_____

Better with (circle all that apply): rest ice heat stretching exercise pain relievers topical creams other:_____

Worse during (circle): morning afternoon evening during sleep

What treatment have you received for this condition (circle): medication physical therapy surgery other:_____

List any area of your life affected by this complaint (ex: work, home, kids, hobbies, etc) 1. _____

2. _____

3. _____

Symptom 3:_____ What happened?_____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 When did the pain start? _____

Quality of pain (circle all that apply): sharp shooting dull ache burning stabbing stiff throbbing numbness

Does your pain radiate into arms? Y N Legs? Y N

Worse with (circle all that apply): sitting standing walking bending lifting other:_____

Better with (circle all that apply): rest ice heat stretching exercise pain relievers topical creams other:_____

Worse during (circle): morning afternoon evening during sleep

What treatment have you received for this condition (circle): medication physical therapy surgery other:_____

List any area of your life affected by this complaint (ex: work, home, kids, hobbies, etc) 1. _____

2. _____

3. _____

FAMILY HISTORY – If present in your family, circle the condition and relation to you below:

Arthritis - grandparent, parent, sibling

Cancer - grandparent, parent, sibling

Diabetes - grandparent, parent, sibling

Heart disease - grandparent, parent, sibling

Autoimmune disease - grandparent, parent, sibling

Back Pain - grandparent, parent, sibling

SOCIAL HISTORY -

How many alcoholic beverages do you consume per week?_____

How many caffeinated beverages do you consume per week?_____

How many times do you workout per week?_____

Do you use recreational drugs?_____ If yes, what type?_____

Do you smoke?_____ If yes, how many times a day?_____

Rate your stress levels on a scale of 1-10 during average week:_____