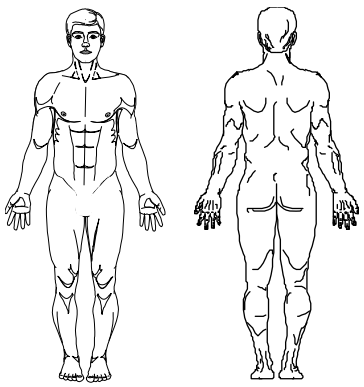
CONFIDENTIAL PATIENT HISTORY

Name _____ Date_____
Address_____ City_____ State_____ ZIP_____
Phone (H)_____ Soc Sec Number_____ Date of Birth_____ Age___
Phone (Work or cell) _____ E-mail address _____
Marital Status S M D W Number of Children_____ Have you been here before? Y N When?_____
Occupation_____ Employer_____ Years there_____
Employer's Address_____ City_____ State_____ Phone (W)_____
Spouse's Name_____ Occupation_____ Employer_____
How did you hear about this office?_____
Are you covered by Medicare? Y N. Are you covered by State Insurance Aid? Y N
Do you have group, union or other personal health insurance? Y N
What is your major complaint?_____
_____
How long have you had this?_____ Have you had this before? Y N When?_____
Have you missed work? Y N How long were you out of work?_____
Other complaints:_____
What activities aggravate your condition?_____
Is this condition getting worse? Y N Is this problem constant or does it come and go?_____
How long since you really felt good? _____
Is this interfering with: Work,Sleep, Daily routine or other _____
List date and type of surgeries or hospitalizations_____
Smoking Status: [ ] Never smoker [ ] Former smoker [ ] Current- sometimes smoker [ ] Current- every day smoker
Do you have any medication allergies? Y N What? _____
Are you currently taking any medications? Y N What? _____
_____
What non-prescription drugs, vitamins or supplements are you taking?_____
Other doctors seen for this condition_____
Family doctor_____ Date of last visit_____ For what?_____
Have you ever seen a Chiropractor? Y N Who?_____ For what?_____
Date of last visit to a Chiropractor_____ Date of last x-rays by a Chiropractor_____
Do you have a pacemaker? Y N Do you have now or have ever had any type of cancer? Y N
Do you have now or have ever had any type of infection? Y N
Are you pregnant or think you might be pregnant? Y N

Please use the pictures below and mark your problem areas with an X.



All of the above information is true and correct. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment for any reason, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ **Date** _____

*******PLEASE TURN OVER AND COMPLETE OTHER SIDE!*******

Please check (X) EVERYTHING that you have EVER had - now OR in the past. Circle L, R, or B for Left, Right, or Both

HEAD

- ☐ Sinus (allergy) headache
- ☐ Entire head headache
- ☐ Back of head headache
- ☐ Forehead headache
- ☐ Side of head (temple) headache (L - R - B)
- ☐ Migraine headache
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision (L - R - B)
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Loss of hearing (L - R - B)
- ☐ Pain in ears (L - R - B)
- ☐ Ringing in ears (L - R - B)
- ☐ Buzzing in ears (L - R - B)
- ☐ Dizziness

NECK

- ☐ Pain in neck
- ☐ Neck pain with movement
- ☐ Bending head forward
- ☐ Bending head backward
- ☐ Turning head to the left
- ☐ Turning head to the right
- ☐ Bending head to the left
- ☐ Bending head to the right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasm in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

SHOULDERS

- ☐ Pain in shoulder joint (L - R - B)
- ☐ Pain across shoulders
- ☐ Bursitis in shoulder (L - R - B)
- ☐ Arthritis in shoulder (L - R - B)
- ☐ Can't raise arm above shoulders (L - R - B)
- ☐ Can't raise arm over head (L - R - B)
- ☐ Tension in shoulders (L - R - B)
- ☐ Pinched nerve in shoulder (L - R - B)
- ☐ Muscle spasm in shoulders (L - R - B)

ARMS & HANDS

- ☐ Pain in upper arm (L - R - B)
- ☐ Pain in elbow (L - R - B)
- ☐ Moving aggravates the pain
- ☐ Tennis elbow (L - R - B)
- ☐ Pain in forearm (L - R - B)
- ☐ Pain in hands (L - R - B)
- ☐ Pain in fingers (L - R - B)
- ☐ Pins & needles in arms (L - R - B)
- ☐ Pins & needles in fingers (L - R - B)
- ☐ Arms are numb / go to sleep (L - R - B)
- ☐ Fingers are numb / go to sleep (L - R - B)
- ☐ Hands cold (L - R - B)
- ☐ Arthritis/swelling in hands/fingers (L - R - B)
- ☐ Loss of grip strength (L - R - B)

MIDDLE BACK

- ☐ Middle Back Pain
- ☐ Pain between shoulder blades
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area (L - R - B)

CHEST

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

ABDOMEN

- ☐ Nervous stomach
- ☐ Can't eat certain foods
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

LOW BACK

- ☐ Upper low back pain
- ☐ Lower low back pain
- ☐ Sacroiliac (SI) or hip pain (L - R - B)
- ☐ Slipped, bulging or herniated disk
- ☐ Low back feels out of place
- ☐ Muscle spasm
- ☐ Arthritis

HIPS, LEGS & FEET

- ☐ Pain in buttocks (L - R - B)
- ☐ Pain in hip joint (L - R - B)
- ☐ Pain down leg (L - R - B)
- ☐ Knee pain (L - R - B)
- ☐ Leg cramps (L - R - B)
- ☐ Foot cramps (L - R - B)
- ☐ Pins & needles feeling (L - R - B)
- ☐ Numbness in leg (L - R - B)
- ☐ Numbness in foot (L - R - B)
- ☐ Numbness in toes (L - R - B)
- ☐ Cold feet (L - R - B)
- ☐ Swollen feet (L - R - B)
- ☐ Swollen ankle (L - R - B)
- ☐ Arthritis

WOMEN ONLY

- ☐ Menstrual pain
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle_____ days
- ☐ Birth control type_____
- ☐ Hysterectomy

MEN ONLY

- ☐ Trouble starting urination
- ☐ Excessive night urination
- ☐ Prostate pain or swelling
- ☐ Frequent urination

GENERAL

- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep_____hours
- ☐ Loss of sleep_____hours
- ☐ Loss of weight____pounds
- ☐ Gain weight_____pounds
- ☐ Coffee_____cups per day
- ☐ Tea_____cups per day
- ☐ Cigarettes _____ pack per day
- ☐ Diabetes
- ☐ Hypoglycemia

MY PAIN IS WORSE WHEN:

- ☐ Working
- ☐ Lifting
- ☐ Stooping
- ☐ Standing
- ☐ Sitting
- ☐ Bending
- ☐ Coughing
- ☐ Lying down (sleeping)
- ☐ Walking
- ☐ Other_____

MY PAIN IS BETTER WHEN I:

- ☐ Rest
- ☐ Use ice
- ☐ Use heat
- ☐ Stretch
- ☐ Move around
- ☐ Work
- ☐ Stand
- ☐ Sit
- ☐ Get adjusted by a Chiropractor
- ☐ Get it massaged
- ☐ Lay down
- ☐ Walk
- ☐ Take drugs:_____
- ☐ Rub on a cream / salve / ointment
- ☐ Take time off of work
- ☐ Other:_____

OTHER REMARKS BELOW:

_____

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