

Patient History (Please Print)

Date: _____

Name: _____ Email: _____

Phone: (Home) _____ (Mobile) _____ (Work) _____

Address: _____ City: _____ Zip: _____

Birth Date: ___/___/___ Male Female Spouse/Parent Name: _____

of Children: _____ Married Single Divorced Widowed

Are you Pregnant? YES NO Due Date: _____

Occupation: _____ Social Security # (for Medicare patients): _____

How were you referred to our office? _____

If from the internet, name of search engine and key words used: _____

Have you ever had Chiropractic Care before? _____ If yes, when? _____

List your chief complaints in order of severity; Check all those that describe your condition:

Complaint 1: _____ For How Long? _____
What originally caused this problem? _____
Feels Like: <input type="checkbox"/> Sharp <input type="checkbox"/> Throbbing <input type="checkbox"/> Shooting <input type="checkbox"/> Cramps <input type="checkbox"/> Stiffness <input type="checkbox"/> Dull Ache <input type="checkbox"/> Numb/Tingling <input type="checkbox"/> Burning <input type="checkbox"/> Other: _____
Bothers Me: <input type="checkbox"/> Constant (100%) <input type="checkbox"/> Frequent (50%-75%) <input type="checkbox"/> Occasional (25%-50%) <input type="checkbox"/> Intermittent (1%-25%)
It Has Been: <input type="checkbox"/> Getting Worse <input type="checkbox"/> Staying Same <input type="checkbox"/> Getting Better
Pain Scale: (0=No Pain – 10=Severe Pain) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
During The Day It Is: <input type="checkbox"/> Worse in the AM <input type="checkbox"/> Stays the same throughout the day <input type="checkbox"/> Worse in the PM
The Following Increases Pain: <input type="checkbox"/> Moving <input type="checkbox"/> Sitting <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Walking <input type="checkbox"/> Laying Down <input type="checkbox"/> Other: _____
The Following Decreases Pain: <input type="checkbox"/> Moving <input type="checkbox"/> Sitting <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Walking <input type="checkbox"/> Laying Down <input type="checkbox"/> Other: _____
Does The Pain Travel/Radiate? : <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where _____ to _____

Complaint 2: _____ For How Long? _____
What originally caused this problem? _____
Feels Like: <input type="checkbox"/> Sharp <input type="checkbox"/> Throbbing <input type="checkbox"/> Shooting <input type="checkbox"/> Cramps <input type="checkbox"/> Stiffness <input type="checkbox"/> Dull Ache <input type="checkbox"/> Numb/Tingling <input type="checkbox"/> Burning <input type="checkbox"/> Other: _____
Bothers Me: <input type="checkbox"/> Constant (100%) <input type="checkbox"/> Frequent (50%-75%) <input type="checkbox"/> Intermittent (25%-50%) <input type="checkbox"/> Occasional (1%-25%)
It Has Been: <input type="checkbox"/> Getting Worse <input type="checkbox"/> Staying Same <input type="checkbox"/> Getting Better
Pain Scale: (0=No Pain – 10=Severe Pain) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
During The Day It Is: <input type="checkbox"/> Worse in the AM <input type="checkbox"/> Stays the same throughout the day <input type="checkbox"/> Worse in the PM
The Following Increases Pain: <input type="checkbox"/> Moving <input type="checkbox"/> Sitting <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Walking <input type="checkbox"/> Laying Down <input type="checkbox"/> Other: _____
The Following Decreases Pain: <input type="checkbox"/> Moving <input type="checkbox"/> Sitting <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Walking <input type="checkbox"/> Laying Down <input type="checkbox"/> Other: _____
Does The Pain Travel/Radiate? : <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where _____ to _____

Complaint 3: _____ For How Long? _____

What originally caused this problem? _____

Feels Like:

- Sharp Throbbing Shooting Cramps Stiffness Dull Ache Numb/Tingling
 Burning Other: _____

Bothers Me:

- Constant (100%) Frequent (50%-75%) Intermittent (25%-50%) Occasional (1%-25%)

It Has Been:

- Getting Worse Staying Same Getting Better

Pain Scale: (0=No Pain – 10=Severe Pain)

- 1 2 3 4 5 6 7 8 9 10

During The Day It Is:

- Worse in the AM Stays the same throughout the day Worse in the PM

The Following Increases Pain:

- Moving Sitting Lifting Bending Walking Laying Down Other: _____

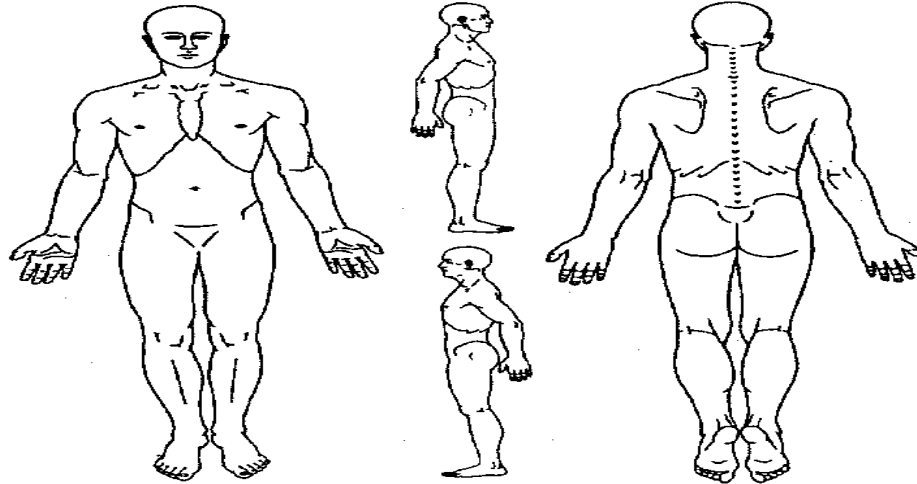
The Following Decreases Pain:

- Moving Sitting Lifting Bending Walking Laying Down Other: _____

Does The Pain Travel/Radiate? :

- Yes No If yes, where _____ to _____

Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels. Include all affected areas.



Does your condition interfere with your:

- | | | | | |
|---------------|-----------------------------|-------------------------------|-----------------------------------|---------------------------------|
| Work | <input type="checkbox"/> NO | <input type="checkbox"/> MILD | <input type="checkbox"/> MODERATE | <input type="checkbox"/> SEVERE |
| Sleep | <input type="checkbox"/> NO | <input type="checkbox"/> MILD | <input type="checkbox"/> MODERATE | <input type="checkbox"/> SEVERE |
| Daily Routine | <input type="checkbox"/> NO | <input type="checkbox"/> MILD | <input type="checkbox"/> MODERATE | <input type="checkbox"/> SEVERE |
| Recreation | <input type="checkbox"/> NO | <input type="checkbox"/> MILD | <input type="checkbox"/> MODERATE | <input type="checkbox"/> SEVERE |

Does your condition interfere with any of the following:

- | | | |
|---------------------------------------|----------------------------------------|---------------------------------------|
| <input type="checkbox"/> Computer Use | <input type="checkbox"/> Cleaning | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Sports | <input type="checkbox"/> Cooking | <input type="checkbox"/> Gardening |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Watching Kids | <input type="checkbox"/> School |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Yard Work | <input type="checkbox"/> Self Care |
| <input type="checkbox"/> Vacuuming | <input type="checkbox"/> Driving | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Social Life | <input type="checkbox"/> Relationship | |

Health History (Check if you have now or have had in the past:)		
<input type="checkbox"/> Abdominal Aortic Aneurysm <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Alcoholism <input type="checkbox"/> Allergy Shots <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Bulimia <input type="checkbox"/> Buzzing/Ringing in Ears <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Chronic Tonsillitis <input type="checkbox"/> Constipation <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Diarrhea <input type="checkbox"/> Digestive Problems <input type="checkbox"/> Dysmenorrhea <input type="checkbox"/> Eczema <input type="checkbox"/> Emphysema	<input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Eye Troubles <input type="checkbox"/> Fractures <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Issues <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herniated Disc <input type="checkbox"/> Herpes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Hypertension/ HBP <input type="checkbox"/> Indigestion <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Menstrual Problems <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mumps <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker <input type="checkbox"/> Parkinson's <input type="checkbox"/> Pneumonia <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Swollen Ankles <input type="checkbox"/> Throat Conditions <input type="checkbox"/> Thyroid Conditions <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors/Growths <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Unexplained Memory Loss <input type="checkbox"/> Unexplained Weight Loss <input type="checkbox"/> Unexplained Weight Gain <input type="checkbox"/> UTI <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Other: _____

Family History (please list all known conditions/illnesses that may apply):

Mother: _____ Father: _____

Grandparents: _____ Siblings: _____

Other known familial conditions: _____

List of Current Medications/Supplements:

List other doctors consulted for condition:

1: _____ 2: _____

3: _____ 4: _____

Concerns:

We've found that these are the common concerns people like you have. We want to make sure you are comfortable before we start care. Add any others that are relevant and **circle your top 3.**

Is it going to hurt?	I don't want to be cracked
Do I have to come forever?	Is it addictive?
Are the X-rays dangerous?	Is it safe for children?
Is it expensive?	What if insurance does not cover chiropractic?
What do I do if chiropractic does not work?	Can this be fixed?

Strengths:

Strong habits are key to health. It helps us take care of you if we have an idea of how you take care of your body. Add any others that are relevant and **circle your top 3.**

Stretch 3-5 times a week	Exercise 3-5 times a week
Drink ½ my body weight of ounces of water	Take supplements for health
Have a positive attitude	Sleep 6-8 hours a night
Drink or eat something green everyday	Get maintenance chiropractic 2-4 times a year
Do activities to minimize stress regularly	Non-smoker

Goals:

We want to make sure you get lasting relief and enjoy maximum functional improvement. Add any others that are relevant and **circle your top 3.**

Sleep through the night	Exercise again
Continue working/get back to work	Avoid future flare ups
Play with kids/grandkids normally	Get off pain medications
Be ready for an upcoming event	Have a better attitude
Have some moments of relief	Sit/stand comfortably for an extended period

List of Previous Hospital Stays/Surgeries: (What and When?)

List of Any Childhood Traumas / Accidents / Falls / Auto Injuries: (What happened and When?)

Is there anything else you think we should know about or that you would like to discuss? (Explain):

Are you interested in Nutritional Services? (i.e, Nutritional Consultation, Hair Mineral Analysis, or Nutrient Analysis)

YES NO

Patient's Signature: _____ **Date:** _____

**Notice: Not all patients require x-rays to determine or verify a diagnosis, type and length of care.
If your examination warrants x-ray analysis, the following office policy prevails:
All first visit charges are to be paid when services are rendered.
The fee paid for x-rays is for analysis only.
The film itself is the property of this office and cannot be released.**

***** If you have insurance please give your card to the front desk staff*****