PERSONAL HISTORY

Name: ______________________ Birthdate: ______________ Sex: Male Female

Address: ______________________ Marital status: ☐ S ☐ M ☐ D ☐ W

City: ______________________ State: ______________ Zip: ______________

Home phone: ______________________ Cell phone: ______________________

Business phone: ______________________ Email: ______________________

Business employer: ______________________ Type of work: ______________________

Name of spouse: ______________________ Name and ages of children: ______________________

Referred to this office by: ______________________ Relationship: ______________________

Responsible for your bill? You and: ☐Spouse ☐Worker's Comp. ☐Auto Insurance ☐Medicare ☐Medicaid

☐ Personal Health Insurance (Name):______________________ Health Card #: ______________________

Insured person's name: ______________________ Date of Birth: ______________________

CURRENT HEALTH CONDITION

Unwanted condition: ______________________

How would you rate this pain, on average: *No Pain* 0 1 2 3 4 5 6 7 8 9 10 *Unbearable*

How much does it restrict your daily activities? *No Restrictions* 0 1 2 3 4 5 6 7 8 9 10 *Unable to Perform*

The pain is: dull aching sharp shooting burning throbbing deep nagging other ______________

Does the pain radiate or travel to any areas of your body? ______________________

Do you have any numbness or tingling in your body? ______________________

How often do you experience the pain? ______________________

Does anything aggravate the pain? ______________________

Does anything make the pain better? ______________________

Other doctors seen for this condition: ☐ Yes ☐ No Who? ______________________

Type of treatment: ______________________ Results: ______________________

Do you have a family doctor? ______________________ Who: ______________________

When did this condition begin? ______________________ Has this condition occurred before? ☐ Yes ☐ No

Is condition? ☐ Job related ☐ Auto accident ☐ Home injury ☐ Fall ☐ Other: ______________

Date of accident: ______________________ Time of accident: ______________________

Have you made a report to your employer: ☐ Yes ☐ No: ______________________

Patient Initials: ______________ Doctor's Signature: ______________________

Current medications (including supplements): ____

Do you suffer from any condition other than which you are now consulting us? ________________________

____

PAST HEALTH HISTORY

Major surgeries/operation: ______________________________ When: ____________

Major accidents/falls: ______________________________ Describe: ____________________

____

Hospitalization (other than above): ____

____

History of: □ Cancer □ Diabetes □ Stroke □Depression Other: ______________________

Previous chiropractic care: □ None □ Doctor's name and approximate last visit: ________________

SOCIAL HISTORY

Alcohol: □ No □ Yes Drinks per week/type? ______________________________

Nicotine: □ No □ Yes Packs per week? ______________________________

Caffeine: □ No □ Yes Drinks per week/type? ______________________________

Exercise: □ No □ Yes Amount per week/type? ______________________________

Ounces of water consumed/day: ______________________________

Diet consists of: □ White sugar □ White flour □ Whole grains □ Fruits □ Vegetables □High protein

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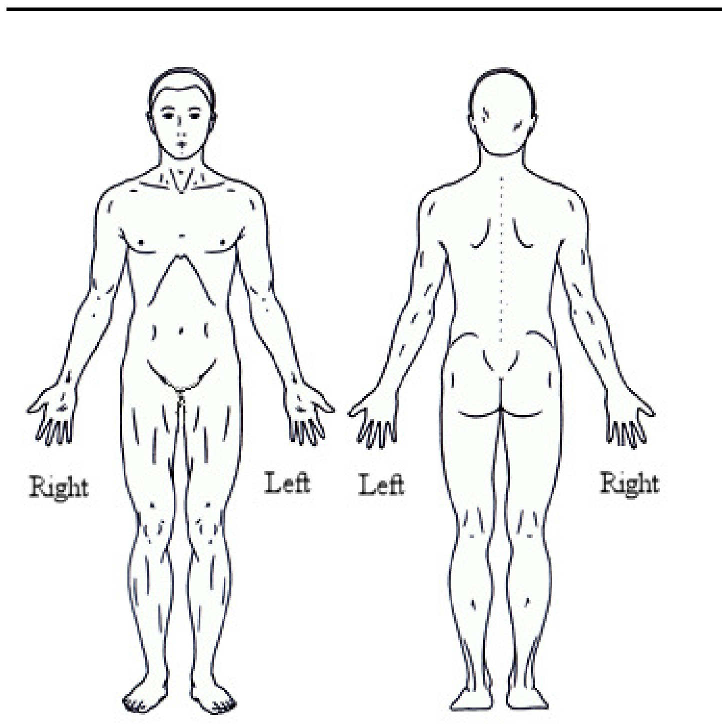

FAMILY HISTORY

History of: □ Cancer □ Diabetes □ Stroke

□Depression Other: ____________________

These members of my family suffer(ed) from similar health concerns as mine:

□ Mother □ Father □ Grandparent(s)

□ Brother □ Sister □ Son □ Daughter

□ Other(s) ____________________

Patient Initials: ________________ *Doctor's Signature:* ______________________________

REVIEW OF SYSTEMS

Please mark any symptom(s) you have experienced in the past or currently experience:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing
__ Fatigue

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earaches
__ Ringing in Ears
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Recent Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy ______________

FOR WOMEN ONLY
__ Birth Control _________
__ Hormone Replacement
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Currently pregnant? Y / N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient Signature: ____ Date: ______________________________

Patient Initials: __________________ Doctor's Signature: ____