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:_________________________
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? _________________________

Is this injury related to a work injury or automobile accident? □ Yes □ No
Have you reported the injury to your employer? □ Yes □ No
PLEASE NOTIFY THE FRONT OFFICE TEAM TO LET THEM KNOW YOU WERE INJURED AT WORK OR AUTOMOBILE ACCIDENT.

Do you have any health insurance? □ Yes □ No
Name of PCP______________________________Phone______________________________
PLEASE GIVE YOUR HEALTH INSURANCE CARD TO THE FRONT OFFICE TEAM IF YOU HAVE HEALTH INSURANCE
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:
□ 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)
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
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 ______________________________

Complaint 2: ___________________________________ 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)
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
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 ______________________________

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

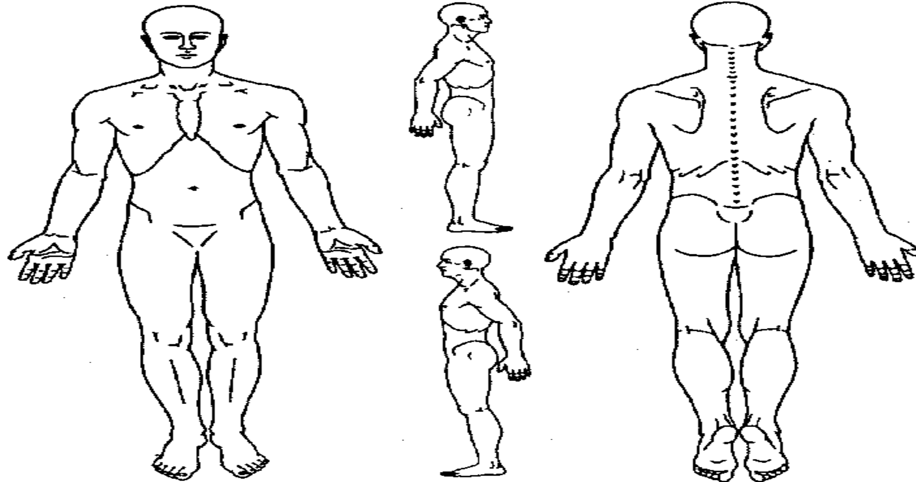
Pain Scale: (0=No Pain – 10=Severe Pain)
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

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 you:

Work	□ NO	□ Causes slight increase in pain	□ Have to alter job duties	□ Can't work
Daily Routine	□ NO	□ Causes Increase in pain	□ Need help due to increase in pain	
Recreation	□ NO	□ Causes Increase in pain	□ Have to change workout	□ Can't do

If your condition interferes with the following please answer, Pain prevents me from:

Sitting more than	□ >1hr	□ 1/2hr	□ 10min	□ I avoid sitting
Standing: I can't stand longer than	□ 1 hour	□1/2 hr	□ 10min	□ I avoid standing
Walking: I can't walk longer than	□ 1mile	□1/2mile	□1/4mile	□ I avoid walking
Sleep disturbed □ <1hr sleepless	□ 1-2hr sleepless	□ 2-3hr sleepless	□ >3hrs sleepless	

List any other activities you are unable to perform:__________

Patient's Signature: ________________________ **Date:** ______________

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Does your condition interfere with any of the following:

- ☐ Computer Use
- ☐ Sports
- ☐ Reading
- ☐ Exercise
- ☐ Vacuuming
- ☐ Social Life
- ☐ Cleaning
- ☐ Cooking
- ☐ Watching Kids
- ☐ Yard Work
- ☐ Driving
- ☐ Relationship
- ☐ Shopping
- ☐ Gardening
- ☐ School
- ☐ Self Care
- ☐ Other: ______________

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

Mother: ____ Father: ____

Grandparents: ______________________________________ Siblings: ______________________________________

Other known familial conditions: ____

Social History:

Smoking ☐ Do not smoke ☐ Smoke 1 pack or less per day ☐ Smoke more than 1 pack per day

Alcohol ☐ I don't drink alcohol ☐ Drink alcohol occasionally ☐Drink alcohol often

Exercise ☐ I don't exercise ☐ Exercise occasionally ☐ Exercise often

Stress ☐ Experience stress occasionally ☐ Experience stress often

List of Current Medications/Supplements:

____

____

____

List of Previous Hospital Stays/Surgeries:

____

____

____

List of Any Childhood Traumas / Past Accidents / Falls / Auto Injuries:

____

____

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:** __________________________

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REVIEW OF SYSTEMS

GENERAL CONSTITUITIONAL

Fatigue ☐Now ☐Past
Fever ☐Now ☐Past
Weakness ☐Now ☐Past
Weight Loss ☐Now ☐Past
Anxiety ☐Now ☐Past
Depression ☐Now ☐Past
Cancer Type______ ☐Now ☐Past

BIOOD/LYMPH

Bruising ☐Now ☐Past

BREASTS

Lumps ☐Now ☐Past
Pain ☐Now ☐Past
Discharge ☐Now ☐Past

EARS, NOSE, THROAT, AND MOUTH

Hearing Loss ☐Now ☐Past
Earache ☐Now ☐Past
Discharge ☐Now ☐Past
Ringing ☐Now ☐Past
Soreness ☐Now ☐Past
Swallowing ☐Now ☐Past
Infection ☐Now ☐Past
Hoarseness ☐Now ☐Past
Bleeding ☐Now ☐Past
Loss of Smell ☐Now ☐Past
Obstruction ☐Now ☐Past
Sinus Problems ☐Now ☐Past
Bad Breath ☐Now ☐Past
Bleeding Gums ☐Now ☐Past
Ulcers ☐Now ☐Past
Dental Problems ☐Now ☐Past
Loss of Taste ☐Now ☐Past

EYES, VISION

Blurry ☐Now ☐Past
Double ☐Now ☐Past
Pain ☐Now ☐Past
Floaters ☐Now ☐Past

GASTROINTESTINAL

Abdominal Pain ☐Now ☐Past
Nausea ☐Now ☐Past
Vomiting ☐Now ☐Past
Diarrhea ☐Now ☐Past
Constipation ☐Now ☐Past
Bloody Stool ☐Now ☐Past
Black Stool ☐Now ☐Past
Jaundice ☐Now ☐Past
Heartburn ☐Now ☐Past
Hemorrhoids ☐Now ☐Past
Belching ☐Now ☐Past
Loss of Appetite ☐Now ☐Past

GENITOURINARY

Urinary Hesitancy ☐Now ☐Past
Incontinence ☐Now ☐Past
Urgency ☐Now ☐Past
Frequency ☐Now ☐Past
Painful Urination ☐Now ☐Past
Kidney Stones ☐Now ☐Past
Kidney Failure ☐Now ☐Past
Dialysis ☐Now ☐Past

HEAD

Headaches ☐Now ☐Past
Injuries ☐Now ☐Past
Dizziness ☐Now ☐Past

HEART, CARDIOVASCULAR

Chest Pain ☐Now ☐Past
Cold extremity ☐Now ☐Past
Ankle Edema ☐Now ☐Past
Murmur ☐Now ☐Past
Varicosity ☐Now ☐Past
Blood Clots ☐Now ☐Past
Palpitations ☐Now ☐Past
Abnormal Heart Rhythm ☐Now ☐Past

MAN

Impotence ☐Now ☐Past
Loss of Libido ☐Now ☐Past
Dribbling ☐Now ☐Past

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REVIEW OF SYSTEMS

MUSCULOSKELETAL

Joint Pain or Swelling	□Now	□Past
Restricted Range of Motion	□Now	□Past
Musculoskeletal Pain	□Now	□Past
Arthritis Type_____________	□Now	□Past

NEUROLOGICAL

Numbness or tingling sensation	□Now	□Past
Sensation Loss	□Now	□Past
Burning	□Now	□Past

RESPIRATORY

Shortness of breath	□Now	□Past
Cough	□Now	□Past
Wheezing	□Now	□Past

SKIN AND INTEGUMENTARY

Rashes	□Now	□Past
Itching	□Now	□Past
Dryness	□Now	□Past
Mole Changes	□Now	□Past
Sores	□Now	□Past
Painful Sex	□Now	□Past

WOMAN

Painful Sex	□Now	□Past
Discharge	□Now	□Past
Irreg Periods	□Now	□Past
Hot Flashes	□Now	□Past
Loss of Libido	□Now	□Past

Went over with the patient Doctor's Signature____

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:

1. 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 the front desk your card *****

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