

Patient History (Please Print)

Date: _____

Name: _____ Email: _____
Phone: (Home) _____ (Mobile) _____ (Work) _____
Address: _____ City: _____ Zip: _____
Birth Date: ____/____/____ Male Female Spouse/Parent Name: _____

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: <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"/> 0 <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 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"/> 0 <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 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 _____

List other doctors consulted for condition:

1: _____ 2: _____
3: _____ 4: _____

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 | |

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

Mother: _____ Father: _____
Grandparents: _____ Siblings: _____
Other known familial conditions: _____

Social History:

Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____
Children: No ____ Yes ____ How Many? _____
Use of Alcohol: None ____ Yes ____ How Much and Often? _____
Use of Tobacco: Never ____ Quit ____ Yes ____ How Much and Often? _____

List of Current Medications/Supplements:

List of Previous Hospitalization / Surgeries / Traumas / Falls / Auto Accidents:

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

Authorization and Release

I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services I may need and release information to others if necessary for my care.

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

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

Review of Systems

Gastrointestinal

Uncontrollable Bowels	No	Yes
Nausea	No	Yes
Vomiting	No	Yes
Heartburn	No	Yes
Black Stool	No	Yes
Red blood in stool	No	Yes
Abdominal pain	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Loss of appetite	No	Yes
Bloating	No	Yes

Constitutional

Cancer	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Recent weight gain	No	Yes
Recent weight loss	No	Yes
Pain at night	No	Yes

Genitourinary

Frequent urination	No	Yes
Kidney failure/dialysis	No	Yes
Uncontrollable Bladder	No	Yes

Neurological

Seizures	No	Yes
Headaches	No	Yes
Dizziness	No	Yes

HEENT

Sore throat	No	Yes
Hoarseness	No	Yes

Cardiovascular

Stroke / TIA	No	Yes
Heart Attack	No	Yes
Abnormal heart rhythm	No	Yes
Chest pain	No	Yes
High Blood Pressure	No	Yes
Peripheral Vascular Disease	No	Yes

Respiratory

Cough	No	Yes
Shortness of breath on exertion	No	Yes
Shortness of breath at rest	No	Yes
Wheezing	No	Yes

Dermatology

Rash	No	Yes
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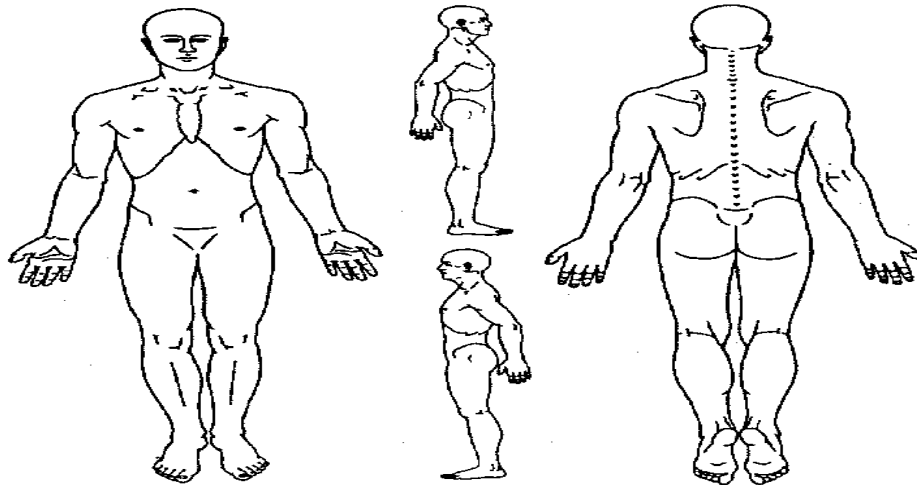
Endocrine

Diabetes	No	Yes
Thyroid Disease	No	Yes

Musculoskeletal

Joint pain	No	Yes
Arthritis	No	Yes
Arthritis Type _____:		

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



I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. To the best of my knowledge, all questions on these forms have been accurately answered.

Went over ROS with patient Dr signature: _____

Patient Signature: _____ **Date:** _____