Confidential Patient History

Date_____

Patients Name_____ Date of Birth_____

Address_____City_____State_____Zip_____

SS#_____ Home phone_____ Work _____

Cell_____ Email address _____

☐ Male ☐ Female Marital Status ☐ S ☐ M ☐ D ☐ W Number of children_____

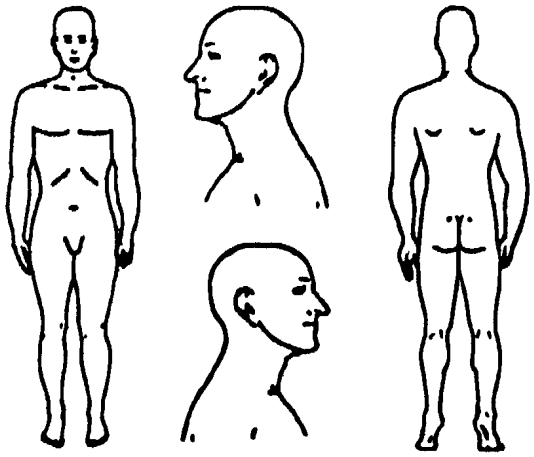
Occupation_____ Employer or School Name_____

How were you referred to our office? _____

Have you had Chiropractic care before? ☐Yes ☐No For what complaint? _____

Have you had any auto or other accidents? ☐ No ☐ Yes Describe:

_____



Mark the areas of pain on the diagram below

Main reason for consulting the office:

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity level

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)?

_____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? ☐ YES ☐ NO

Rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

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Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: _____

What activities aggravate your condition? (working, exercise, etc)

_____

What makes your pain better? (ice, heat, massage, etc) _____

How often do you experience your symptoms? ☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Rate your overall / general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you exercise? Type of exercise? _____ Frequency? _____

Do you smoke? ☐Yes ☐No How much? _____

Allergies: ☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs ☐ Latex ☐ Molds ☐ Penicillin

☐ Ragweed/Pollen ☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye

Other _____

Surgeries: ☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist

Other: _____

ALL Past Medical History conditions: ☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones

☐ Cancer ☐ Chest Pain ☐ Depression ☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting

☐ Fatigue ☐ Foot Pain ☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems ☐ Hepatitis

☐ High Blood Pressure ☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Menstrual Problems

☐ Mid-Back Pain ☐ Minor Heart Problem ☐ Multiple Sclerosis ☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker

☐ Parkinson's ☐ Polio ☐ Prostate Problems ☐ Shoulder Pain ☐ Significant Weight Change ☐ Spinal Cord Injury

☐ Sprain/Strain ☐ Stroke/Heart Attack Other_____

Medications you are taking: ☐ Anxiety ☐ Muscle Relaxors ☐ Pain Killers ☐ Insulin ☐ Birth control ☐ Cardiovascular ☐ Allergy

☐ Seizure Other: _____

Are you allergic to any medications: ☐ No ☐ Yes _____

Family History: ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy

☐ Genetic Spinal Condition ☐ High Blood Pressure ☐ Heart Problems ☐ Multiple Sclerosis ☐ Neurological Problems

☐ Parkinson’s ☐ Polio ☐ Prostate Problems ☐ Stroke/Heart Attack