



PATIENT HISTORY

Dear Patient: The completion of this form is a sensible first step prior to experiencing the many benefits associated with chiropractic care. This form has been designed to assist with delivering the most appropriate chiropractic care and/or identifying any possible risk factors to your health and safety to provide appropriate care and advice. Please provide the answers that represent your case to the best of your knowledge as your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

NAME _____ DATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ WORK PHONE _____

DATE OF BIRTH (MM/DD/YYYY) ___/___/___ AGE ___ M F MARITAL STATUS _____ NO. OF CHILDREN _____ FAX # _____

OCCUPATION _____ SSN# _____ SPOUSE: _____ E-MAIL: _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ REFERRED BY _____

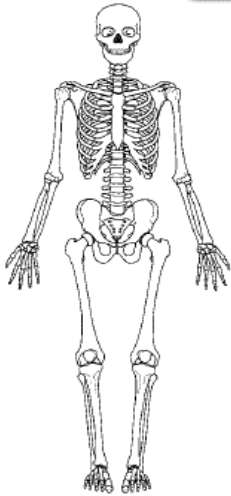
IN CASE OF EMERGENCY (Name of relatives or close friend not living in your home):

NAME: _____ ADDRESS: _____ PHONE _____

Please label the area of complaint with the following numbers:

- 1 = Dull 2 = Throbbing 3 = Muscle tightness 4 = Numbness 5 = Sharp * = Other: _____

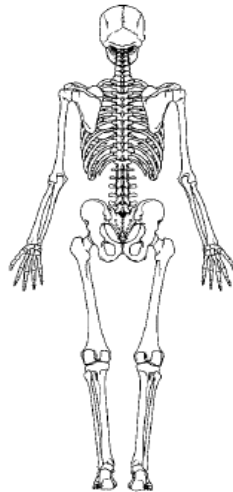
Mark Areas of Complaint



Anterior Skeleton



Lateral Skeleton



Posterior Skeleton

What is your major complaint? _____

Other complaints _____

Have you ever had previous chiropractic care? _____ If yes, date of last care _____

Do you have Health and Accident Insurance? _____ If yes, with what company? _____

Regarding your current condition:

How long have you had this condition? _____ Have you had this or similar condition in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily routine Other _____

List previous diagnoses and treatments you have received for present condition _____

What do you believe is wrong with you? _____

Are you on any medications? Yes No Please List: _____

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Used a cane, crutch, or other support?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized for other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a motor vehicle accident or serious injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had any X-rays, CT scans, MRI, Ultrasound?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had any unexplained weight loss?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had any recent changes in a mole or freckle?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had any unusual lumps or swellings?	<input type="checkbox"/>	<input type="checkbox"/>	_____

DO YOU:			
Now take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have an allergy to any drug?	<input type="checkbox"/>	<input type="checkbox"/>	_____

HABITS	Heavy	Moderate	Light	Past Use	None	LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE PAST 10 YEARS
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Below are items that may seem unrelated to the purpose of your appointment. However, please answer these items carefully as they can affect your overall course of chiropractic care. Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. REST ASSURED THAT THIS IS A CONFIDENTIAL HEALTH REPORT.

O – Occasional

F – Frequent

C – Constant

O F C GENERAL

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Neuralgia
- Numbness
- Sweats
- Tremors

O F C MUSCLE & JOINT

- Arthritis
- Bursitis
- Foot Trouble
- Hernia
- Back Pain
- Neck pain or stiffness
- Pain between shoulders
- Poor posture
- Sciatica
- Spinal curvature
- Swollen joints
- Muscle Spasms/Cramping

Pain or numbness in:

- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Tail bone

O F C GASTRO-INTESTINAL

- Belching or gas
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Vomiting
- Vomiting of blood

O F C CARDIO-VASCULAR

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Swelling of ankles

O F C RESPIRATORY

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up phlegm
- Wheezing

O F C SKIN

- Boils
- Bruise easily
- Dryness
- Itching
- Skin eruptions (rash)
- Varicose veins

O F C GENITO-URINARY

- Bed-wetting
- Blood in urine/Stool
- Frequent urination
- Inability to control bladder
- Kidney infection or stones
- Painful urination
- Prostate trouble

O F C FOR WOMEN ONLY

- Congested breast
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal menstruation
- Vaginal discharge
- Yes No Are you pregnant?

O F C EYES, EARS, NOSE, THROAT

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental decay
- Earache
- Ear discharge
- Ear noise
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Hay fever
- Hoarseness
- Nasal obstruction
- Nosebleeds
- Sinus infection
- Sore throat
- Tonsillitis

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Influenza | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles miscarriage | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chorea | <input type="checkbox"/> Gout | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Polio | |

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

ANY ADDITIONAL INFORMATION THAT YOU FEEL WOULD BE HELPFUL IN DETERMINING YOUR CONDITION

CANCELLATIONS: We ask that you respect our cancellation policy to ensure we have enough time to contact other clients on our waiting list. 24 hours' notice is required for cancellation or re-scheduling. If notice is not received, a cancellation fee will be charged.