

PATIENT HISTORY

Name: _____ **Preferred Name:** _____
Street: _____ **Apt:** _____
City: _____ **State:** _____ **Zip:** _____
Home Phone: _____-_____-____ **Work Phone:** _____-_____-____ **Cell Phone**:** _____-_____-____
Email Address:** _____ **Marital Status:** S M W D
Date of Birth: _____ **Social Security #:** _____-_____-____ **Gender:** Male Female

Race: ___ White ___ American Indian or Alaska Native ___ Asian ___ Black or African American
 ___ Native Hawaiian/Other Pacific Islander ___ Decline to Answer ___ Other: _____

Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Decline to Answer

Please list your preferred Language: _____

How did you hear about our office? _____ **Referral by:** _____

** We use your email address to subscribe you to our newsletter. Emailed monthly, each edition includes tips, tools, and wellness resources. Please check this box if you DO NOT want to receive this. You can visit our website to subscribe at any time.*

*** Would you like to receive a text or email reminder for your scheduled appointments? Yes or No*

List any **Non Medication Allergies:**

Animal Bees Chocolate Dairy Dust Eggs Latex Molds Ragweed/Pollen Rubber
 Seasonal Allergies Shellfish Soaps Wheat X-Ray Dye Other: _____

List any **Surgeries:**

Back Brain Elbow Foot Hip Knee Neck Neurological Shoulder Wrist
 Other: _____

List **ALL Past Medical History** conditions:

Primary Care Physician: _____ **Phone Number:** _____

Date of last physical examination: _____

ADD/ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leg Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ankle Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low back Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arm Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scoliosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hand Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Broken Bones	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Menstrual Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Significant Weight Change	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hip Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mid-Back Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sprain/Strain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Inflammatory Bowel Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke/Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No
Elbow Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Knee Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No		

List any **medications and what condition this medication is treating** that you are currently taking: (Attach a list if necessary)

Medications: _____

Nutritional Supplements: _____

Medication Allergies: _____

Family History (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother, **P**aternal Grandfather (**PG**), Paternal Grandmother (**PM**), Maternal Grandfather (**MF**), Maternal Grandmother (**MM**).

____ Arthritis ____ Cancer ____ Diabetes ____ Heart Disease ____ Multiple Sclerosis ____ Scoliosis ____ Stroke ____ Other

Social History

Alcohol: Never Social Consumption Beer Wine Liquor ____ (#) of ____ oz. per Day Week Month

Tobacco: Deny tobacco use Live with a smoker Quit Smoking ____ year Smoke/Chew; # ____ / day/week/month

Caffeine: No Yes - how many per day? _____ **Use recreational drugs?** No Yes Quit

Education: Please list the highest level completed: _____

Diet: Please list any special diet of which we should be aware: _____

Exercise: No Yes (what forms and how often): _____

Sleep: How many hours of consecutive sleep do you get on weekdays? _____ weekends? _____

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

Employment:

Occupation: _____ **Work** _____ hours per day

Job Classification: Sedentary (lift less than 5 lbs) Light (6-20 lbs) Moderate (21-49 lbs) Heavy (over 50 lbs)

What **percentage** of time during the day (at home or at your job away from home) do you spend:

Lifting ____ Sitting ____ Bending ____ Working at a computer ____ Phone ____

Are there any other problems you want to discuss with the chiropractor?

- ADHD / ASD / Behavior issues Carpal Tunnel Exercise counseling Fatigue Foot Pain/ Orthotics Headaches
- Knee Pain Shoulder pain Sleep issues Stress Vitamins/supplements Weight loss Wellness care

Do you have any other medical records you would like us to have? If so, from whom? _____

Please speak to the front desk if you need a requisition form for us to request these records

X _____
Signature of patient or person acting on patients behalf

Date

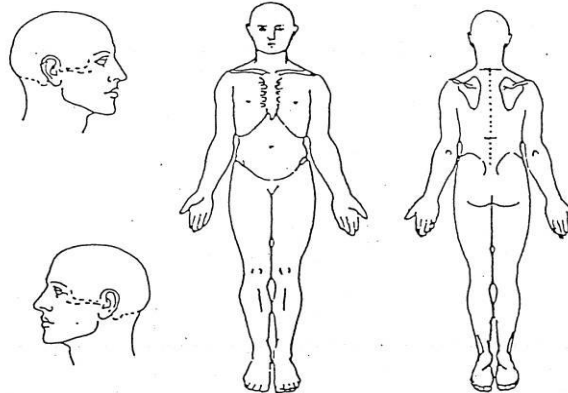
Have you ever had chiropractic care? No Yes

When? _____ Why? _____ Where? _____ Date of last adjustment _____

Were X-rays taken? No Yes If so, when? _____

1. What is your MAJOR complaint? _____ Date problem began? _____
2. How did this problem begin (falling, lifting, etc.)? _____
3. How is your condition changing? Getting Better Getting Worse Not Changing
4. Have you had this condition in the past? Yes No
5. Please circle the number below to indicate level of problem (0= no symptoms and 10 = excruciating symptoms)
 0 1 2 3 4 5 6 7 8 9 10
6. Please rate the intensity of the pain: Minimum Mild Moderate Severe Unbearable None
7. Describe the nature of your symptoms:
 Burning Dull Ache Numb Radiating Pain Sharp Shooting Tightness Tingling Throbbing
8. What makes your pain better (ice, heat, massage, etc)? _____
9. What are your expectations for care? Become pain free Explanation of my condition
 Learn how to care for this on my own Reduce symptoms Resume normal activity
10. 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)
11. What activities aggravate your condition (working, exercise, etc)? _____
12. What treatment have you already received for your condition? Medications Surgery Injections Physical Therapy
 Chiropractic Services Massage Therapy None Other _____
 Name of other doctor (s) who have treated you for your condition _____

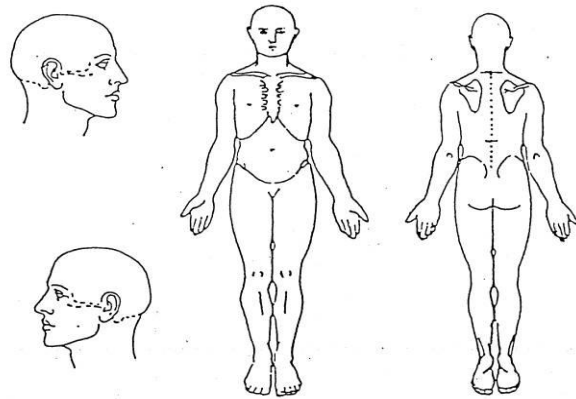
Mark the area (s) on your body where you feel the
 Described sensation (s).



Additional Comments:

1. Do you have a SECOND complaint? _____ Date problem began? _____
2. How did this problem begin (falling, lifting, etc.)? _____
3. How is your condition changing? Getting Better Getting Worse Not Changing
4. Have you had this condition in the past? Yes No
5. Please circle the number below to indicate level of problem (0= no symptoms and 10 = excruciating symptoms)
 0 1 2 3 4 5 6 7 8 9 10
6. Please rate the intensity of the pain: Minimum Mild Moderate Severe Unbearable None
7. Describe the nature of your symptoms:
 Burning Dull Ache Numb Radiating Pain Sharp Shooting Tightness Tingling Throbbing
8. What makes your pain better (ice, heat, massage, etc)? _____
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 Chiropractic Services Massage Therapy None Other _____
 Name of other doctor (s) who have treated you for your condition _____

Mark the area (s) on your body where you feel the
 Described sensation (s).



Additional Comments:

Review of Systems- Please fill out each section even if section is "I do not have any..."

Constitutional: I do not have constitutional issues

- Chills Daytime Somnolence (drowsiness) Fatigue Fever Night Sweats Weight Gain Weight Loss

Eyes/Vision: I do not have eye/vision issues

- Blindness Blurred Vision Cataracts Change in Vision Double Vision Eye Pain Visual field defect
 Glaucoma Itching (around the eyes) Photophobia Tearing Wear Glasses and/or Contact Lenses

Ears, Nose and Throat: I do not have ears, nose and throat issues

- Bleeding Dental Implants Dentures Difficulty Swallowing Discharge Dizziness Ear Drainage
 Ear Infection(s) Ear Pain Fainting Headaches Head Injury (history of) Hearing Loss Hoarseness
 Loss of Smell Nasal Congestion Nose Bleeds (frequent) Post Nasal Drip Rhinorrhea (runny nose)
 Sinus Infection Snoring Sore Throats (frequent) Tinnitus (ringing in ears) TMJ (jaw) Problems

Respiration: I do not have respiratory issues

- Asthma Cough Coughing up Blood Shortness of Breath Coughing Phlegm Wheezing

Cardiovascular : I do not have cardiovascular issues

- Angina (chest pain or discomfort) Chest Pain Claudication (leg pain or achiness) Heart Murmur Heart Problems
 Orthopnea (difficulty breathing while laying down) Palpitations (irregular or forceful beating of the heart)
 Paroxysmal Nocturnal Dyspnea (waking up at night with shortness of breath)
 Shortness of Breath with Exertion or Exercise Swelling of Legs Ulcers Varicose Veins

Gastrointestinal : I do not have gastrointestinal issues

- Abdominal Pain Belching Black, Tarry Stools Constipation Diarrhea
 Difficulty Swallowing Heartburn Hemorrhoids Indigestion Jaundice (yellowing of the skin) Nausea
 Rectal Bleeding Abnormal Stool Color Abnormal Stool Consistency Vomiting Ulcers Vomiting Blood

Female : I do not have female issues

- Birth Control Therapy Breast Lumps/Pain Burning Urination Cramps Frequent Urination Hormone Therapy
 Irregular Menstruation Urine Retention Vaginal Bleeding Vaginal Discharge

Male : I do not have male issues

- Burning Urination Erectile Dysfunction Frequent Urination Hesitancy/Dribbling Prostate Problems
 Urine Retention

Skin : I do not have skin issues

- Changes in Nail Texture Changes in Skin Color Hair Growth Hair Loss Hives Itching
 Paresthesia (numbness, prickling, tingling) Rash History of Skin Disorders Skin Lesion/Ulcers Tremors

Nervous System : I do not have nervous system issues

- Dizziness Facial Weakness Headaches Limb Weakness Loss of Consciousness Loss of Memory Numbness
 Seizures Sleep Disturbance Slurred Speech Stress Strokes Tremors Unsteadiness of Gait

Psychological : I do not have psychological issues

- Anhedonia (inability to experience joy or enjoy life) Anxiety Appetite Changes Behavioral Changes
 Bipolar Disorder Confusion Convulsions Depression Insomnia Memory Loss Mood Changes

Allergy : I do not have allergy issues

- Anaphylaxis (history of) Food Intolerance Itching Nasal Congestion Sneezing

Hematology (Blood) : I do not have hematology issues

- Anemia Bleeding Blood Clotting Blood Transfusion (s) Bruises Easily Fatigue Lymph Node Swelling

Ob/Gyn: I do not have ob/gyn issues

I... have never been pregnant have been pregnant in the past am currently pregnant _____ Due Date
 _____ Number of pregnancies _____ # of complicated pregnancies _____ # of uncomplicated pregnancies
 _____ # of miscarriages _____ # of terminated pregnancies _____ # of epidural injection
 _____ # of C-sections _____ # of vaginal deliveries

Menstrual History Age of onset _____ My menses is Regular Irregular
 I am currently in Peri-menopause Menopause Date of last menses ____/____/____

Condition's Effect on Daily Life

	No Effect	Mild (painful, can do)	Moderate (painful/limited)	Severe (unable to do)
Bending				
Caring for Family				
Carrying groceries				
Change position (sit/stand)				
Climbing Stairs				
Daily Pet Care				
Driving				
Extended Computer Use				
Eating				
Household Chores				
Kneeling				
Lifting				
Reading				
Self-Care-Bath, Dressing etc				
Sexual Activities				
Sleep				
Sitting Still				
Standing Still				
Walking				
Yard Work				
Other _____				

Would you like a copy of your electronic medical records from our office for yourself or sent to another provider? Yes No
 If yes, please indicate how you would like these sent: Email _____ Fax _____ Paper Copy

MY PRIVACY

I have been offered or received copy of the **Notice of Privacy Practices**. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payers; Conduct normal healthcare operations such as quality assessments and accreditation.

X _____ Date
 Signature of patient or person acting on patients behalf