WELLNESS CHIROPRACTIC
move well · eat well · be well

20 East Blue Hill Road
PO Box 326
Tel: 207-374-2186
Fax: 207-374-5235
www.mywellnesschiro.com

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: _____

List any **Non Medication Allergies**:
□ Animal □ Bees □ Chocolate □ Dairy □ Dust □ Eggs □ Latex □ Molds □ Ragweed/Pollen □ Rubber
□ Seasonal Allergies □ Shell fish □ Soaps □ Wheat □ X-Ray Dye □ Other:_____

List any **Surgeries, and write in the date**:
□ Ankle _____ □ Back _____ □ Elbow _____ □ Foot _____ □ Hip _____ □ Knee _____ □ Neck _____
□ Neurological _____ □ Shoulder _____ □Wrist _____ □ Other:_____

List **ALL Past Medical History** conditions:

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

Primary Care Physician: _____ **City/Town:** _____

Date of last physical examination: _____

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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, Paternal Grandfather (**PG)**, Paternal Grandmother **(PM**), Maternal Grandfather (**MF**), Maternal Grandmother (**GM**).

_____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: _____
Have you had any concussions? _____

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

If you have any other medical records you would like us to have, i.e., x-rays, blood work, office notes, please inform the front desk staff.

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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

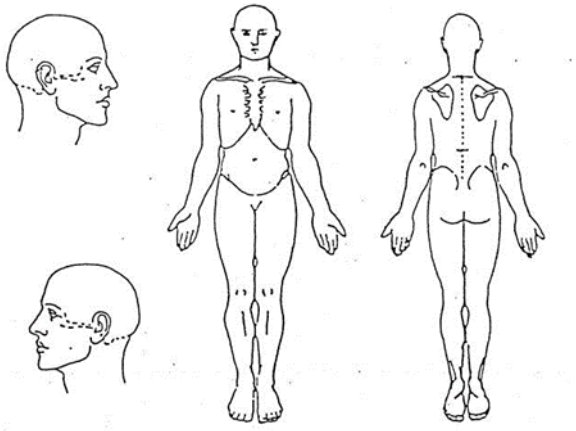
   □ Learn how to care for this on my own □ Reduce symptoms □ Resume normal activity
10. How often do you experience your symptoms? □ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

    □ 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.



Additional Comments:

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If you have a SECOND complaint, please fill out this page; otherwise, you can skip page 4 and move to page 5.

1. What is your 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)?_____
9. What are your expectations for care? □ Become pain free □ Explanation of my condition

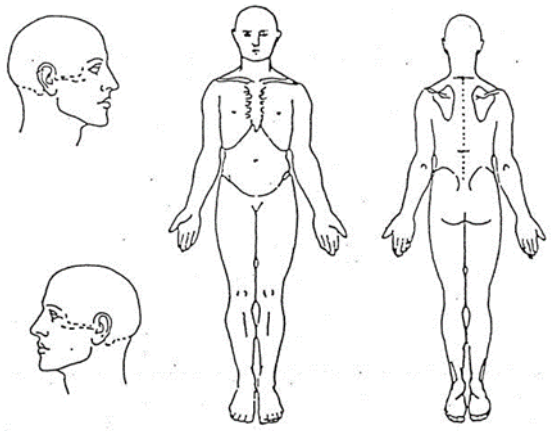
   □ Learn how to care for this on my own □ Reduce symptoms □ Resume normal activity
10. How often do you experience your symptoms? □ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

    □ 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 this 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.



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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 pan 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

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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_____				

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 □ Pre-menopause □ Menopause Date of last menses _____/ _____/_____

Would you like a copy of your electronic medical records from our office for yourself ? Yes No
Or sent to another provider**?** _____

MY PRIVACY

I have received a 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 _____ _____

Signature of patient or person acting on patients behalf Date