Today's Date _____

Section 1: Patient Health History

Patient Name _____

Address_____

_____

Primary Phone _____ Mobile Phone _____

email _____

(By providing my email address, I authorize my doctor to contact me via the email address provided.)

Contact Method (check one) ❑ Primary Phone ❑ Mobile Phone ❑ Email

Date of Birth _____ Age _____ Gender ❑ Male ❑ Female ❑ Unspecified

SS# _____ Marital Status (check one) ❑ Single ❑ Married ❑ Other

Name of Spouse _____ Spouse's Phone Number _____

Names & Ages of Children (at home) _____

_____

Employment (check one) ❑ Employed ❑ Student ❑ Retired ❑ Other

Employer _____ Job Title _____

Primary Daily Activities ❑ Sitting//Desk work ❑ Computer ❑ Standing ❑ Walking/Moving ❑ Lifting

Current Medications, including start date, frequency and dosage if known. If there are no current medications, check here ❑

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Section 2: Current Health Problem

Briefly list your primary health concern(s): _____

_____

When did this begin? _____

How frequent does it occur? _____

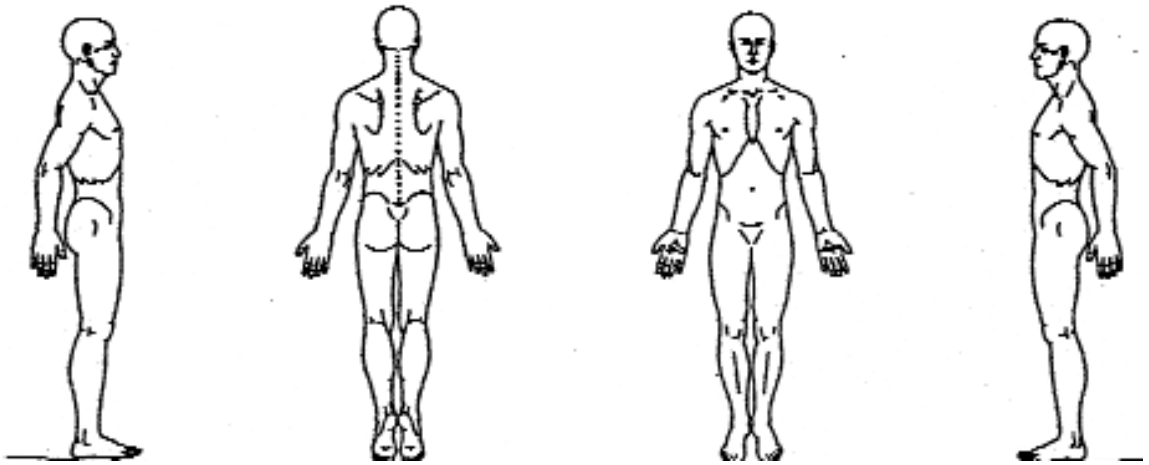
Please describe the above condition in detail: _____

_____

Mark the area on your body where you feel the sensation(s) described below and include all affected areas.

Numbness ----------

Pins & Needles
oooooo
Burning Pain
xxxxxxxxx
Stabbing Pain
//////////
Aching Pain
((((((((



Please circle the pain level that most accurately represents your pain:

	NO PAIN										UNBEARABLE PAIN
a) Right Now	0	1	2	3	4	5	6	7	8	9	10
b) Average Pain	0	1	2	3	4	5	6	7	8	9	10
c) At Best	0	1	2	3	4	5	6	7	8	9	10
d) At Worst	0	1	2	3	4	5	6	7	8	9	10

We would like to know how much your pain presently prevents you from doing what you would normally do. Please indicate the overall impact your present pain has on your life, not just when the pain is at its worst.

1. FAMILY/AT -HOME RESPONSIBILITIES such as yard work, chores around the house or driving the kids to school
   0 1 2 3 4 5 6 7 8 9 10
   Completely able to function ***Totally unable to function***

2. RECREATION including hobbies, sports or other leisure activities
   0 1 2 3 4 5 6 7 8 9 10

3. SOCIAL ACTIVITIES including parties, theater, concerts, dining-out and attending social functions
   0 1 2 3 4 5 6 7 8 9 10

4. EMPLOYMENT including volunteer work and homemaking tasks
   0 1 2 3 4 5 6 7 8 9 10

5. SELF -CARE such as taking a shower, driving or getting dressed
   0 1 2 3 4 5 6 7 8 9 10

6. LIFE -SUPPORT ACTIVITIES such as eating and sleeping
   0 1 2 3 4 5 6 7 8 9 10

Was there an accident, injury or condition that could have brought this problem about or be related to it? (Example: fall, auto injury, work injury, sports trauma, repetitive motion on the job) ❑ Yes ❑ No If yes, describe: _____

_____

Have you experienced this problem before? ❑ Yes ❑ No When? _____

Who have you consulted with prior to today's visit about this problem? _____

What is this person's specialty or health care discipline? _____

What was their diagnosis and treatment recommendation? _____

_____

Section 3: Additional Health History

List any diagnostic tests done within the last year (X-Ray, MRI, CAT Scan, blood tests, etc.) _____

_____

Have you had previous chiropractic care? ❑ Yes ❑ No If yes, when was your last adjustment? _____

What did you like/dislike about your chiropractic care? _____

Please describe any physical factors or environmental problems at work that impact your health, safety or job satisfaction (for example: temperature, workspace set-up, chemical exposure, relations with coworkers, etc.):

_____

Please list any surgery - when and what type: _____

_____

Have you been in an auto accident? (If your current complaint is due to an auto accident, have there been any prior auto accidents?) ❑ Past Year ❑ Past Five Years ❑ Over five years ❑ Never

Describe: _____

HAVE YOU EVER:	YES	NO	Describe Briefly
Been knocked unconscious?	❑	❑	_____
Used a cane, crutch, or other support?	❑	❑	_____
Had a fractured bone?	❑	❑	_____
Been hospitalized for anything other than surgery?	❑	❑	_____
Been treated for a spine or nerve disorder?	❑	❑	_____
Had orthodontic braces or appliances?	❑	❑	_____

If you have now or have had any of the following conditions, check the appropriate box:
If it was a problem in the past and does not bother you currently, check **P=Past**. If it is a current problem check one of the following **O=Occasional, F=Frequent, C=Constant**

General:

P	O	F	C	
☐	☐	☐	☐	allergy
☐	☐	☐	☐	bleeding/bruising
☐	☐	☐	☐	depression/moodiness
☐	☐	☐	☐	dizziness/fainting
☐	☐	☐	☐	fatigue
☐	☐	☐	☐	headaches
☐	☐	☐	☐	poor sleep
☐	☐	☐	☐	rashes/hives
☐	☐	☐	☐	sudden weight loss/gain
☐	☐	☐	☐	grinding/clenching teeth
☐	☐	☐	☐	jaw problems
☐	☐	☐	☐	swollen joints

Eyes, Ears, Nose & Throat:

☐	☐	☐	☐	hearing loss
☐	☐	☐	☐	difficulty swallowing
☐	☐	☐	☐	earaches
☐	☐	☐	☐	eye pain
☐	☐	☐	☐	ringing in ears
☐	☐	☐	☐	sinus problems

Genito-Urinary:

☐	☐	☐	☐	bed wetting
☐	☐	☐	☐	bladder infection
☐	☐	☐	☐	blood in urine
☐	☐	☐	☐	frequent urination
☐	☐	☐	☐	inability to control kidneys
☐	☐	☐	☐	painful urination
☐	☐	☐	☐	prostate trouble

Cardiovascular:

☐	☐	☐	☐	high/low blood pressure
☐	☐	☐	☐	poor circulation
☐	☐	☐	☐	rapid/slow heartbeat
☐	☐	☐	☐	swollen ankles

Gastrointestinal:

☐	☐	☐	☐	bloody bowel movements
☐	☐	☐	☐	constipation
☐	☐	☐	☐	diarrhea
☐	☐	☐	☐	difficult/painful digestion
☐	☐	☐	☐	heartburn/acid reflux
☐	☐	☐	☐	hemorrhoids
☐	☐	☐	☐	hiatal hernia
☐	☐	☐	☐	intestinal gas
☐	☐	☐	☐	ulcers

Women Only:

☐	☐	☐	☐	fibrocystic breasts
☐	☐	☐	☐	ovarian cysts
☐	☐	☐	☐	endometriosis
☐	☐	☐	☐	premenstrual syndrome
☐	☐	☐	☐	excessive menstruation
☐	☐	☐	☐	painful menstruation
☐	☐	☐	☐	irregular cycle
☐	☐	☐	☐	uterine fibroids
☐	☐	☐	☐	menopausal symptoms: hot flashes, mood changes vaginal dryness, memory fog, insomnia, hair loss, dry skin

Are you pregnant? ☐ Yes ☐ No

Respiratory:

☐	☐	☐	☐	asthma
☐	☐	☐	☐	chest pain
☐	☐	☐	☐	chronic cough/phlegm
☐	☐	☐	☐	difficulty breathing
☐	☐	☐	☐	spitting up blood

Have you been diagnosed with:

☐	☐	☐	☐	Alcoholism
☐	☐	☐	☐	Anemia
☐	☐	☐	☐	Arthritis
☐	☐	☐	☐	Cancer
☐	☐	☐	☐	Chronic Fatigue Synd.
☐	☐	☐	☐	Diabetes/Hypoglycemia
☐	☐	☐	☐	Eczema
☐	☐	☐	☐	Emphysema
☐	☐	☐	☐	Epilepsy
☐	☐	☐	☐	Fibromyalgia
☐	☐	☐	☐	Gallstones
☐	☐	☐	☐	Heart Disease
☐	☐	☐	☐	Irritable Bowel Synd.
☐	☐	☐	☐	Kidney Stones
☐	☐	☐	☐	Lupus
☐	☐	☐	☐	Lymes Disease
☐	☐	☐	☐	Multiple Sclerosis
☐	☐	☐	☐	Osteoporosis
☐	☐	☐	☐	Scoliosis
☐	☐	☐	☐	Stroke
☐	☐	☐	☐	Hypo/Hyper Thyroid
☐	☐	☐	☐	Other _____

Section 4: Health Habits

Habits:	Heavy	Moderate	Light	None	
Alcohol	❑	❑	❑	❑	
Tobacco	❑	❑	❑	❑	
Coffee	❑	❑	❑	❑	
Drugs	❑	❑	❑	❑	
Sleep	❑	❑	❑	❑	❑ Side ❑ Stomach ❑ Back ❑ Restless
T.V.	❑	❑	❑	❑	How many hours per day? _____
Computer	❑	❑	❑	❑	How many hours per day? _____
Fast Food	❑	❑	❑	❑	What type? _____
Soft Drinks	❑	❑	❑	❑	How many per day? _____

How many glasses of water do you drink per day? _____

How many servings of fresh fruits and vegetables do you eat in a typical day? _____

Please list any herbs or nutritional supplements you are taking and the name of the manufacturer:

_____

_____

What type of exercise do you do? _____

How often do you exercise? _____ How long do you exercise? _____

Do you wear: ❑ Heel lifts ❑ Orthotics ❑ Dental Splint

Age of your mattress: _____ ❑ Comfortable ❑ Uncomfortable

What type of pillow do you sleep on? _____

What do you do for fun? _____

What are the three biggest stresses in your life right now:

1. _____ 2. _____ 3. _____

Do you have any other health concerns? _____

On a scale of 1 to 10, with 1 being the lowest, rate your overall state of well-being: _____

What goal would you like to achieve through chiropractic care?

_____

Your Primary Care Doctor: _____ Doctor's Phone #: _____

How did you hear about our practice? _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that I am financially responsible for all charges incurred during the course of my care. I hereby authorize the doctor to release all information in my records necessary to secure my reimbursement of insurance benefits.

Patient Signature: _____ Date: _____

Reviewed by Doctor: _____ Date: _____