

# PATIENT HISTORY

Date \_\_\_\_\_ Dr. \_\_\_\_\_  
 Name \_\_\_\_\_ Referred by \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_ Number of Children \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employment \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Email Address \_\_\_\_\_  
 When did you last see a Chiropractor \_\_\_\_\_ Dr. \_\_\_\_\_

PLEASE FILL IN THE APPROPRIATE SPACES: (All information you give is confidential)

**MAJOR COMPLAINT:** \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Date Began \_\_\_\_\_

How did condition begin? \_\_\_\_\_

Have you lost workdays: Yes ( ) No ( ) How many? \_\_\_\_\_

Have you had this similar condition before? Yes ( ) No ( ) When \_\_\_\_\_

Was this injury related to: work accident ( ) auto accident ( )

**Past (O) Present (X) Conditions:**

<p><b>A</b> <u>    </u> <b>FRACURED BONES</b></p> <p><u>    </u> AUTO ACCIDENTS</p> <p>(a) <u>    </u> 0-1 years ago</p> <p>(b) <u>    </u> 1-5 years ago</p> <p>(c) <u>    </u> More than 5 years ago</p> <p><u>    </u> OTHER ACCIDENTS OR FALLS</p> <p><u>    </u> KNOCKED UNCONSCIOUS</p> <p><u>    </u> BACK CURVATURE</p> <p><u>    </u> MENTAL OR EMOTIONAL DISORDERS</p> <p><u>    </u> ARTHRITIS</p> <p><u>    </u> DIABETES</p> <p><u>    </u> SWOLLEN OR PAINFUL JOINTS</p> <p><u>    </u> CONVULSIONS/EPILEPSY</p> <p><u>    </u> SKIN PROBLEMS</p> <p><u>    </u> ITCHING</p> <p><u>    </u> BRUISE EASILY</p> <p><u>    </u> CANCER</p> <p><u>    </u> FREQUENT COLDS/FLUS</p> <p><b>B</b> <u>    </u> <b>NERVOUS</b></p> <p><u>    </u> TENSION</p> <p><u>    </u> DEPRESSED</p> <p><u>    </u> IRRITABLE</p> <p><u>    </u> ANEMIA</p> <p><u>    </u> EXCESS SWEATING</p> <p><u>    </u> TREMORS</p> <p><u>    </u> LIGHT BOTHERS EYES</p> <p><u>    </u> ALLERGY</p> <p><u>    </u> SINUS PROBLEMS</p> <p><u>    </u> LIGHT HEADED UPON RISING</p> <p><u>    </u> UNDER STRESS</p> <p><u>    </u> CRAVE SWEETS OR SALT</p> <p><u>    </u> EATING DISORDERS</p> <p><b>C</b> <u>    </u> TROUBLE SLEEPING</p> <p><u>    </u> TROUBLE CONCERTRATING</p> <p><u>    </u> LOSS OF MEMEORY</p>	<p><u>    </u> LEARNING DISABILITIES</p> <p><u>    </u> MISTAKE SIDEDNESS (R FROM L)</p> <p><u>    </u> STUTTER</p> <p><u>    </u> DYSLEXIA</p> <p><u>    </u> MOOD CHANGES</p> <p><u>    </u> LOSE TEMPER EASILY</p> <p><b>D</b> <u>    </u> HEADACHE</p> <p><u>    </u> NECK PAIN OR STIFF NECK R L</p> <p><u>    </u> NUMBNESS, TINGLING OR PAIN IN ARMS</p> <p><u>    </u> HANDS OR FINGERS R L</p> <p><u>    </u> JAW PAIN OR CLICK (TMJ) R L</p> <p><u>    </u> HEAD SEEMS TO HEAVY</p> <p><u>    </u> HEAD &amp; SHOULDERS FEEL TIRED</p> <p><u>    </u> DIFFICULTY IN EXCESSIVE</p> <p><u>    </u> (STANDING, SITTING, RIDING, BENDING,</p> <p><u>    </u> LIFTING, TWISTING, HOUSEHOLD DUTIES)</p> <p><u>    </u> SHOULDER PAIN R L</p> <p><u>    </u> DIZZINESS</p> <p><u>    </u> RINGING IN EARS R L</p> <p><u>    </u> HEARING LOSS R L</p> <p><u>    </u> FAINTING</p> <p><u>    </u> LOSS OF BALANCE</p> <p><u>    </u> BLURRED OR DOUBLE VISION R L</p> <p><u>    </u> UPPER BACK PAIN OR STIFFNES R L</p> <p><u>    </u> MID BACK PAIN OR STIFFNESS R L</p> <p><u>    </u> LOW BACK PAIN OR STIFFNES R L</p> <p><u>    </u> NUMBNESS, TINGLING OR PAIN IN</p> <p><u>    </u> BUTTOCKS, THIGHS, FEET, LEGS, TOES R L</p> <p><u>    </u> PAIN WITH COUGH, SNEEZE, OR STRAIN AT</p> <p><u>    </u> STOOLS</p> <p><u>    </u> HIP PAIN R L</p> <p><u>    </u> FOOT TROUBLE R L</p> <p><b>E</b> <u>    </u> CHEST PAIN</p> <p><u>    </u> ASTHMA</p> <p><u>    </u> LUNG PROBLEMS</p> <p><u>    </u> DIFFICULT BREATHING</p>	<p><u>    </u> WHEEZING</p> <p><u>    </u> HEART PROBLEMS</p> <p><u>    </u> STROKE</p> <p><u>    </u> HIGH OR LOW BLOOD</p> <p><u>    </u> PRESSURE</p> <p><u>    </u> VARICOSE VEINS</p> <p><u>    </u> LIVER TROUBLE</p> <p><u>    </u> GALL BLADDER TROUBLE</p> <p><b>F</b> <u>    </u> DIGESTIVE PROBLEMS</p> <p><u>    </u> EXCESSIIVE GAS</p> <p><u>    </u> BELCHING/BLOADING AFTER</p> <p><u>    </u> MEALS</p> <p><u>    </u> HEARTBURN</p> <p><u>    </u> ULCERS</p> <p><u>    </u> DIARHEA/CONSTIPATION</p> <p><u>    </u> COLON TROUBLE</p> <p><u>    </u> HEMMORHOIDS</p> <p><u>    </u> PROSTRATE PROBLEMS</p> <p><u>    </u> IMPOTENCE</p> <p><b>G</b> <u>    </u> KIDNEY TROUBLE</p> <p><u>    </u> KIDNEY STONES</p> <p><u>    </u> FREQUENT URINATION</p> <p><u>    </u> PAINFUL URINATION</p> <p><u>    </u> DISCHARGE</p> <p><u>    </u> MENSTRAL PROBLEMS/PMS</p> <p><u>    </u> MENOPAUSE PROBLEMS</p> <p><u>    </u> BREAST LUMPS, SORENESS</p> <p><u>    </u> DISCHARGE</p> <p><u>    </u> PREGNANT (NOW)</p> <p><u>    </u> BEDWETTING</p> <p><u>    </u> EAR INFECTIONS</p> <p><u>    </u> HEPATITIS</p> <p><u>    </u> VENERAL DISEASE</p> <p><u>    </u> AIDS/HIV</p>
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What is your Health Philosophy?

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HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

\_\_\_\_\_ Temporary Relief (Help the symptom but do not fix the cause of the problem)

\_\_\_\_\_ Maximum correction (Correct the cause of the problem for maximum stability in the future)

WHAT SURGERIES HAVE YOU HAD? \_\_\_\_\_

HISTORY OF MOTOR VEHICLE ACCIDENTS (INCLUDE DATE AND DESCRIPTION) \_\_\_\_\_

\_\_\_\_\_

LIST DRUGS YOU NOW TAKE (PRESCRIPTION AND NON-PRESCRIPTION) \_\_\_\_\_

LIST VITAMINS & HERBS YOU NOW TAKE \_\_\_\_\_

NAME OTHER DOCTORS SEEN FOR THIS CONDITION; WHAT WAS DONE AND FOR HOW LONG: \_\_\_\_\_

ARE YOU WEARING: HEEL LIFTS ( ) ARCH SUPPORTS ( )

1. What are your favorite activities or hobbies to do now? \_\_\_\_\_
2. Are your current problems affecting these activities or hobbies? \_\_\_\_\_
3. What activities are you looking forward to doing in retirement? \_\_\_\_\_
4. Who would you like to be doing these with? \_\_\_\_\_

On a scale of 1-10 (10 being the most, and 1 being the least),

\_\_\_\_\_ How committed are you at being at your maximum health potential?

\_\_\_\_\_ How important is it for your family to be at their maximum health potential?

\_\_\_\_\_ How committed are you to preventing arthritis and maximizing your spinal stability?

**PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES RECEIVED UNLESS SPECIAL ARRANGMENTS ARE MADE IN ADVANCE.**

SIGNATURE \_\_\_\_\_