

## Patient History

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

### ABOUT YOU

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Patient's Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 What do you prefer to be called: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Drivers License #: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
 Other phone #: \_\_\_\_\_ Email address: \_\_\_\_\_  
 May we add you to our email list to keep you updated on any special events at the clinic? Y / N  
 Who may we thank for referring you to our clinic? \_\_\_\_\_  
 Employer: \_\_\_\_\_ How long? \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Status: Married / Divorced / Single / Widowed  
 Do you have children? Yes / No How many? \_\_\_\_\_

### IN CASE OF EMERGENCY

Who should we contact? \_\_\_\_\_ Relation: \_\_\_\_\_  
 Home phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_

### CURRENT PROBLEM

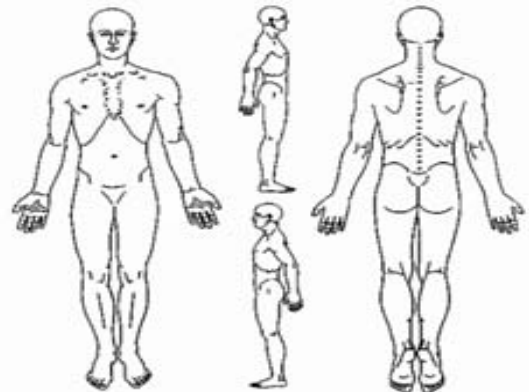
Please describe your main complaint: \_\_\_\_\_  
 How long have you been experiencing this problem? \_\_\_\_\_  
 How often do you experience symptoms? \_\_\_\_\_  
 Is it painful to (check all that apply): \_\_\_\_\_ Sit \_\_\_\_\_ Walk \_\_\_\_\_ Stand \_\_\_\_\_ Bend \_\_\_\_\_ Lie down \_\_\_\_\_ Lift objects  
 Was the injury related to: \_\_\_\_\_ work accident \_\_\_\_\_ auto accident Is this condition getting worse? Y / N  
 Does this condition interfere with: \_\_\_\_\_ Work \_\_\_\_\_ Exercise \_\_\_\_\_ Sleep \_\_\_\_\_ Daily activities \_\_\_\_\_ Recreation  
 Have you lost workdays? Y / N How many? \_\_\_\_\_  
 Have you had a similar condition before? Y / N When? \_\_\_\_\_  
 Have you ever had chiropractic care before? Y / N When? \_\_\_\_\_ Outcome? \_\_\_\_\_  
 Name of treating doctor: \_\_\_\_\_  
 On a scale of 1 through 10 (10 being the most pain imaginable, 0 being the no pain at all), how would you rate your pain right now

1 2 3 4 5 6 7 8 9 10

Using the below index, please mark the diagram with the type of pain you feel in the areas that are painful.

#### Pain Index:

*Sharp/ Stabbing* + + + + +  
*Dull & Achy* V V V V V  
*Stiffness* # # # # #  
*Pin & Needles* O O O O O  
*Numbness* / / / / /  
*Burning* X X X X X



**CONFIDENTIAL HEALTH HISTORY**

Have you ever had surgery or been hospitalized? Y / N List surgeries and date:

Are you taking any of the following medications: (circle all that apply)

*Pain killers / Anti-inflammatories / Muscle relaxers / Stimulants / Nerve pills / Other*

Please list anything that you may be allergic to:

Please list any past serious accidents with dates:

Do you have any family history of cardiovascular disease, cancer, or diabetes? Y / N

**For women only:** Are you pregnant? Y / N \_\_\_\_\_ (Initial)

Do you have, or have you ever had any of the following health problems? **(check all that apply)**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Headaches                    | <input type="checkbox"/> Achyness/General pain    | <input type="checkbox"/> High/Low Blood Pressure     | <input type="checkbox"/> Auto Accidents      |
| <input type="checkbox"/> Migraines                    | <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Excessive Sweating          | <input type="checkbox"/> Falls, etc          |
| <input type="checkbox"/> Neck Pain/Stiffness          | <input type="checkbox"/> Memory loss/Forgetful    | <input type="checkbox"/> Stomach problems            | <input type="checkbox"/> Sports Injuries     |
| <input type="checkbox"/> Shoulder Pain/Stiffness      | <input type="checkbox"/> Frequent colds/Flus      | <input type="checkbox"/> Nausea                      | <input type="checkbox"/> Work Injuries       |
| <input type="checkbox"/> Numbness/Tingling arm(s)     | <input type="checkbox"/> Nervousness              | <input type="checkbox"/> Ulcers                      | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Elbow pain/Stiffness         | <input type="checkbox"/> Irritability             | <input type="checkbox"/> Liver/Gall Bladder problems | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Wrist/Hand pain or stiffness | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Kidney Problems             | <input type="checkbox"/> Mood Disorders      |
| <input type="checkbox"/> Upper Back Pain/Stiffness    | <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Digestion Problems          | <input type="checkbox"/> Emotional Disorders |
| <input type="checkbox"/> Mid Back Pain/Stiffness      | <input type="checkbox"/> Vision/Eye Problems      | <input type="checkbox"/> Diarrhea                    | <input type="checkbox"/> Tension             |
| <input type="checkbox"/> Low Back Pain/Stiffness      | <input type="checkbox"/> Hearing/Ear Problems     | <input type="checkbox"/> Constipation                | <input type="checkbox"/> Stress              |
| <input type="checkbox"/> Hip Pain/Stiffness           | <input type="checkbox"/> Ear Infections           | <input type="checkbox"/> Bladder Problems            | <input type="checkbox"/> Anxiety             |
| <input type="checkbox"/> Knee Pain/Stiffness          | <input type="checkbox"/> Sinus Problems           | <input type="checkbox"/> Incontinence                | <input type="checkbox"/> Poor Diet           |
| <input type="checkbox"/> Ankle/Foot Pain or Stiffness | <input type="checkbox"/> Thyroid Problems         | <input type="checkbox"/> Impotence                   | <input type="checkbox"/> Pain w/ Coughing    |
| <input type="checkbox"/> Pain shooting down leg(s)    | <input type="checkbox"/> Allergies                | <input type="checkbox"/> Prostate problems           | <input type="checkbox"/> Pain w/ Sneezing    |
| <input type="checkbox"/> Trouble walking              | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Bed wetting                 | <input type="checkbox"/> Pain w/ Stools      |
| <input type="checkbox"/> Sore Muscles                 | <input type="checkbox"/> Trouble breathing        | <input type="checkbox"/> Menstrual problem(s)        | <input type="checkbox"/> Restricts Activity  |
| <input type="checkbox"/> Painful joints               | <input type="checkbox"/> Heart problems           | <input type="checkbox"/> Fractured bones             | <input type="checkbox"/> Restricts exercise  |
| <input type="checkbox"/> Tiredness/Fatigue            | <input type="checkbox"/> Circulation problems     | <input type="checkbox"/> Dizziness                   | <input type="checkbox"/> Unable to work      |

Is there anything else you would like to tell the doctor? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_