

CONFIDENTIAL PATIENT HISTORY

Name _____ Date _____ Home Phone _____ Work Phone _____
 Address _____ City _____ State _____ Zip _____ Cell Phone _____
 Date of Birth _____ Age _____ Marital Status _____ Names/Ages of Children _____
 Occupation _____ Employer _____ SSN _____
 Name of Spouse *(parent if minor)* _____ Occupation _____ Employer _____
 Emergency Contact _____ Phone _____ M.D. _____
 Who may we thank for referring you to this office _____ Email _____

REASON FOR VISIT

The reason for this visit is a result of *(please circle)* Auto Work Fall Sports Chronic Other
 Name of Insurance Company (if any) _____ 2nd Insurance _____
 Please describe your major complaint and how it happened _____

Date Started ____/____/____ Had Before? _____

Please Describe _____

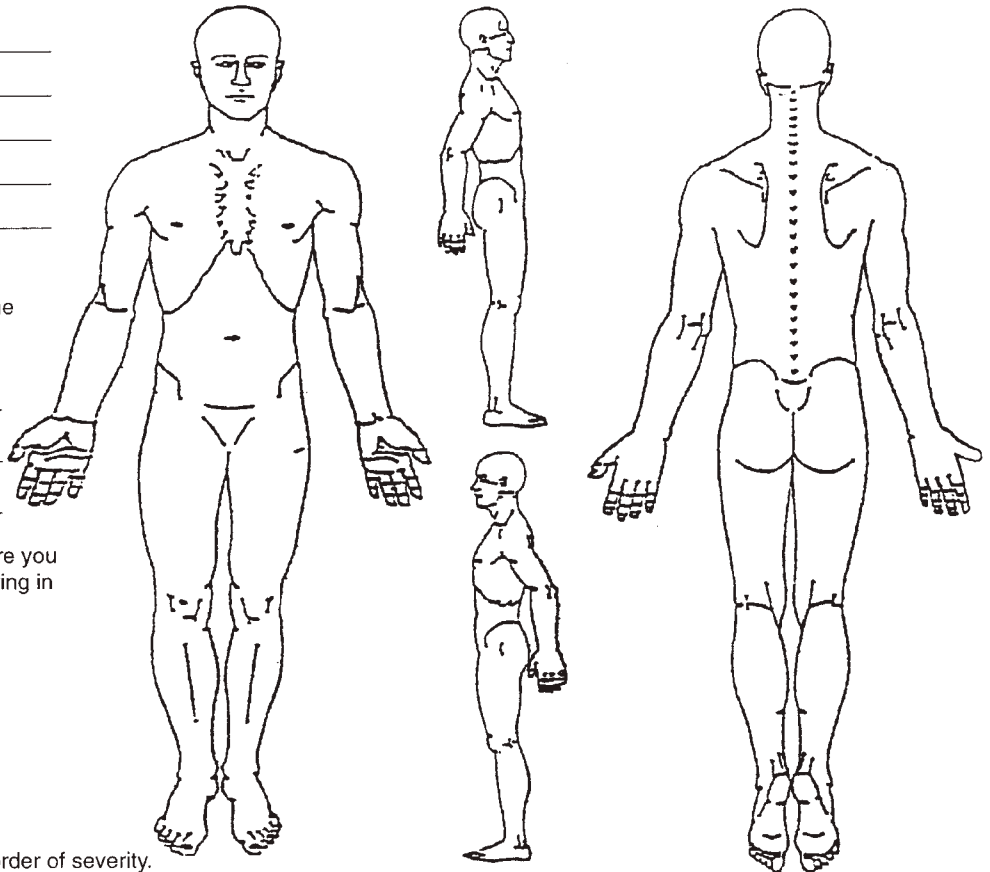
Is this interfering with your *(please circle)*
 Work Sleep Daily Routine
 Sports Recreation Other

If so, please explain _____

In the area to the right, please indicate where you are experiencing pain or symptoms by drawing in the letter abbreviations on the diagrams

(see sample form)

Sharp Pain = P Dull Pain = D
 Stiffness = S Numbness = N
 Tingling = T Burning = B



Please list each area of your symptoms in order of severity. Then at the scale to the right, mark an (X) at a point along the line that demonstrates the level of severity. *(see sample form)*

AREAS OF SYMPTOM

1. _____
2. _____
3. _____
4. _____
5. _____

No pain
or symptoms

SEVERITY

Worst pain
imaginable

HEALTH HISTORY

Have You Had:	Yes	No	Date	Please describe.
Medical Care for this	_____	_____	_____	_____
Surgeries/Fractures	_____	_____	_____	_____
Are you taking medications	_____	_____	_____	_____
Family History of Health Conditions	_____	_____	_____	_____

SPINAL IMPACT HISTORY

Please List Any:	Yes	No	Date	Please describe injuries and what happened.
Recent Auto Accident	_____	_____	_____	_____
Prior Auto Accident	_____	_____	_____	_____
Recent Work Injury	_____	_____	_____	_____
Recent Sport/Recreational Injury	_____	_____	_____	_____
Falls or Other Traumas	_____	_____	_____	_____

Do you have any difficulty with the following:

If you have the condition now, Place an "N" in the space; If in the past, Place an "P".

_____ Abdominal Pain	_____ Colds/Infections	_____ Gall Bladder	_____ Hepatitis	_____ Mental Disorders	_____ Sinus Trouble
_____ Alcoholism	_____ Colon Trouble	_____ Gout	_____ High Blood Pressure	_____ Nausea	_____ Sleeplessness
_____ Allergy	_____ Constipation	_____ Gynecological Problems	_____ HIV / Aids	_____ Nervousness	_____ Stress
_____ Anemia	_____ Depression	_____ Hardening of Arteries	_____ Indigestion	_____ Pneumonia	_____ Stroke
_____ Arthritis	_____ Diabetes	_____ Hearing Problems	_____ Kidney Trouble	_____ Poor Appetite	_____ Thyroid Trouble
_____ Asthma	_____ Dizziness	_____ Heart Disease	_____ Knocked Unconscious	_____ Prostate Problems	_____ Ulcers
_____ Cancer	_____ Epilepsy	_____ Headaches	_____ Liver Trouble	_____ Sciatica	_____ Varicose Veins
_____ Chest Pain	_____ Fatigue	_____ Hemorrhoids	_____ Lung Problems	_____ Short of Breath	_____ Vision Problems
_____ Cold Hands/Feet					_____ Weight Gain / Loss

List any conditions, tests, or exams in the last 10 years we should know about _____

For Females: Are you pregnant? _____ Do you take birth control pills? _____

HEALTH HABITS

Alcohol _____ /wk	Tobacco _____ packs/day	Exercise _____	Work _____ hrs/day
Coffee _____ cups/day	Drugs _____	Sleep _____ hrs/night	Vitamins _____

PERSONAL GOALS

1. What are your favorite hobbies or activities to do now? _____
2. How Are your current problems affecting these activities or hobbies? _____

On a scale of 0-10 (0 being the least and 10 being the most)

- _____ How committed are you at being at your maximum health potential?
_____ How important is it for your family to be at their optimum health potential?

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

- _____ Temporary Relief (Help the symptom but do not fix the problem)
_____ Maximum correction (Correct the cause of the problem for maximum stability in the future)

If you have previously seen a chiropractor, please describe your likes and dislikes (if any) so we may better serve you. _____

Patients signature (or parent's if minor) _____ Date _____