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 ______________
Employer Address ______________________________ City ____________________ State _____ Zip__________
Name of Spouse *(parent if minor)* ______________________ Occupation______________ Employer______________
Emergency Contact ____________________________ Phone ________________ M.D.______________
Who may we thank for referring you to this office? __________________________________ Email ______________
Preferred Name (how you would like to be addressed): ______________________________

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 ____________________

____

____

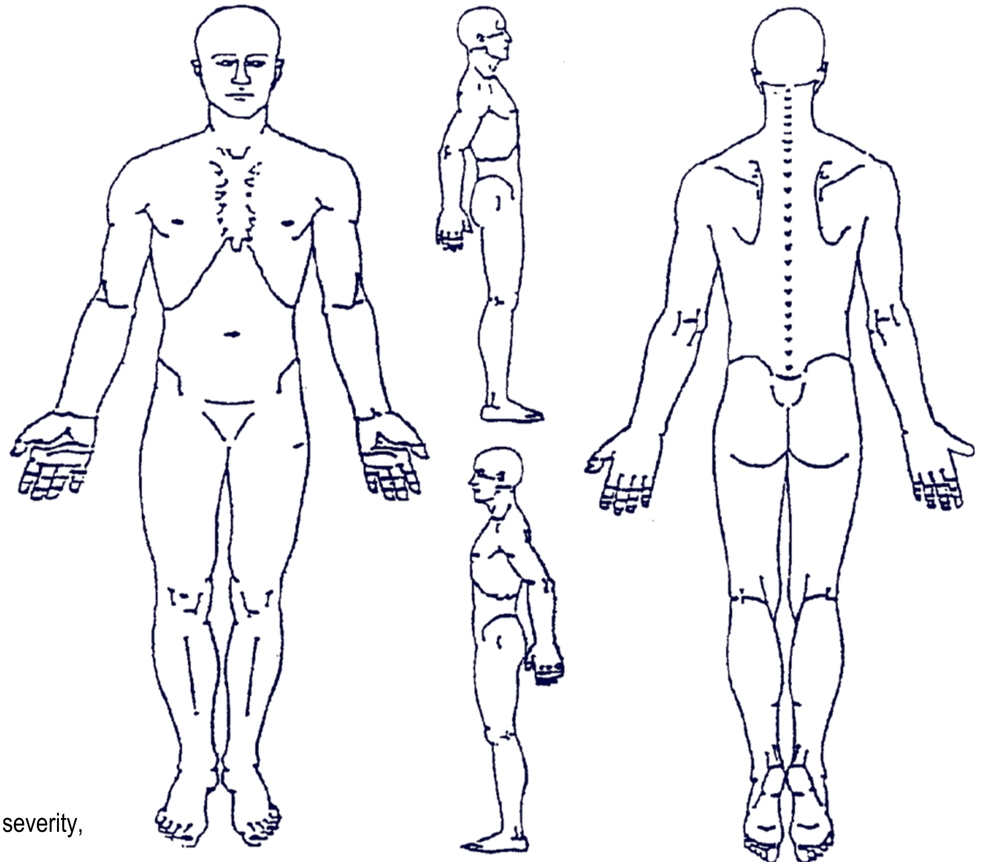
____

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

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) that best represents the level of severity. (See sample form.)

AREAS OF SYMPTOM	No pain or symptoms — SEVERITY — Worst pain imaginable
1. ______________________	______________________
2. ______________________	______________________
3. ______________________	______________________
4. ______________________	______________________
5. ______________________	______________________

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	____	____	______	____________________

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 a "P".

____ **Abdominal Pain**
____ **Alcoholism**
____ **Allergy**
____ **Anemia**
____ **Arthritis**
____ **Asthma**
____ **Cancer**
____ **Chest Pain**
____ **Cold Hands/Feet**
____ **Colds/Infections**
____ **Colon Trouble**
____ **Constipation**
____ **Depression**
____ **Diabetes**
____ **Dizziness**
____ **Epilepsy**
____ **Fatigue**
____ **Gall Bladder**
____ **Gout**
____ **Gynecological Problems**
____ **Hardening of Arteries**
____ **Hearing Problems**
____ **Heart Disease**
____ **Headaches**
____ **Hemorrhoids**
____ **Mental Disease**
____ **Nausea**
____ **Nervousness**
____ **Pneumonia**
____ **Poor Appetite**
____ **Prostate Problems**
____ **Sciatica**
____ **Short of Breath**
____ **Sinus Trouble**
____ **Sleeplessness**
____ **Stress**
____ **Stroke**
____ **Thyroid Trouble**
____ **Ulcers**
____ **Varicose Veins**
____ **Vision Problems**
____ **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 to do now? ______________________________
2. How are you 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 to being at your maximum health potential? If not 8-10, please explain. ______________________________

____

_______ How important is it for your family to be at their optimum health potential? If not 8-10, please explain.______________________________

____

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. ______________________________

____

____

Patient's signature (or parent's, if minor) ______________________________ **Date** ____________________

Name____ Date______________

PATIENT TRAUMA HISTORY

Most patients have had dozens of IMPACTS throughout their life that could cause SUBLUXATIONS (spinal misalignments). The doctor wants to discover at least 5 of yours. List below any auto accidents, work, home, sports injuries, or falls.

1. **When was your most recent/most significant auto accident?** Date?______________
   Briefly Describe:____
   Any treatment received? Y N Describe:__________________ Chiropractic care? Y N

2. **Any previous auto accidents?** Date?______________
   Briefly Describe:____
   Any treatment received? Y N Describe:__________________ Chiropractic care? Y N

3. **When was your most recent/most significant work injury?** Date?______________
   Briefly Describe:____
   Any treatment received? Y N Describe:__________________ Chiropractic care? Y N

4. **Any previous work injuries?** Date?______________
   Briefly Describe:____
   Any treatment received? Y N Describe:__________________ Chiropractic care? Y N

5. **When was your most recent sports/recreational injury?** Date?______________
   Briefly Describe:____
   Any treatment received? Y N Describe:__________________ Chiropractic care? Y N

6. **Any previous sports/recreational injuries?** Date?______________
   Briefly Describe:____
   Any treatment received? Y N Describe:__________________ Chiropractic care? Y N

Please list any other important traumas (i.e. childhood traumas, illnesses, fractures, sprains, surgeries) not mentioned: Date?_______________

Briefly Describe Trauma:____

Any treatment received? Y N Describe:__________________ Chiropractic care? Y N

QUALITY OF LIFE RATINGS

Subluxations affect our quality of life in many ways. Please circle the number that best represents how you rate your quality of life and lifestyle habits.

SLEEP DISTURBANCE (0 = none, 10 = worst imaginable)

0 1 2 3 4 5 6 7 8 9 10

STRESS (0 = none, 10 = worst imaginable)

0 1 2 3 4 5 6 7 8 9 10

FATIGUE (0 = none, 10 = worst imaginable)

0 1 2 3 4 5 6 7 8 9 10

MOVEMENT PROBLEMS (eg. Getting out of a chair, getting out of bed, walking with ease)

0 1 2 3 4 5 6 7 8 9 10

DIET (0 = organic, fruits & veggies, water; 10 = all processed, junk food or fast food, soda)

0 1 2 3 4 5 6 7 8 9 10

FOCUS/CONCENTRATION/MEMORY ISSUES (0 = no problems, 10 = severe problems)

0 1 2 3 4 5 6 7 8 9 10

Lastly, please tell us on average how many days per week you **EXERCISE:**

0 1 2 3 4 5 6 7