

FOR CHIROPRACTIC SERVICES

Patient History

Name _____ Date _____
 Address _____ State _____ Zip _____
 H. Phone (_____) _____ W. Phone _____ Date of Birth _____ Age _____

Have you ever received Chiropractic Care? Yes No

Please circle for each of the following:

	Patient Comment If answer is Yes	Chiropractor's Comments
1. Regarding your Birth Process:		
Was the delivery long/difficult?	Y N _____	_____
Forceps or extraction used?	Y N _____	_____
Cesarean/ C-Section?	Y N _____	_____
Breach/ cephalic?	Y N _____	_____
Home birth?	Y N _____	_____
Hospital birth?	Y N _____	_____
Mother given drugs during delivery?	Y N _____	_____
Was labor induced?	Y N _____	_____
2. Growth and Development/ Childhood:		
Were you breast fed?	Y N _____	_____
Health education?	Y N _____	_____
Childhood illnesses?	Y N _____	_____
Ear infections/ Colic/ Asthma?	Y N _____	_____
Attention Deficit?	Y N _____	_____
Antibiotics?	Y N _____	_____
Drugs, prescription, OTC, recreational?	Y N _____	_____
Surgery?	Y N _____	_____
Hospitalizations?	Y N _____	_____
Sports or other physical activities	Y N _____	_____
Injuries during sports?	Y N _____	_____
Auto accidents?	Y N _____	_____
Did you have other traumas?	Y N _____	_____
Did you ever break any bones?	Y N _____	_____
3. Current Health Habits:		
Did/do you smoke?	Y N _____	_____
Did/do you drink alcohol?	Y N _____	_____
Diet, do you eat healthy foods?	Y N _____	_____
Have you been in accidents/trauma?	Y N _____	_____
Have you had surgery?	Y N _____	_____
Drugs, prescription, OTC, recreational?	Y N _____	_____
Dental problems?	Y N _____	_____
Eye problems?	Y N _____	_____
Hearing problems?	Y N _____	_____
Exercise regularly?	Y N _____	_____
Did/do you have occupational stress?	Y N _____	_____
Drive? Daily time spent driving	Y N _____	_____
Physical stress?	Y N _____	_____
Emotional/Mental stress?	Y N _____	_____
Hobbies/Sports injuries?	Y N _____	_____
Do you sleep well, hours of sleep?	Y N _____	_____
Sleeping posture? O side O stomach O back	_____	_____

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office:

Major _____

Pain or Problem started on _____

Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other _____

Does this pain shoot, radiate, or travel in your body? Where? _____

Are you experiencing numbness or tingling in any area of your body? Where? _____

Since it began, is it: O Same O Better O Worst

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? _____

Is this condition interfering with Work? _____ Sleep? _____ Routine? _____ Other? _____

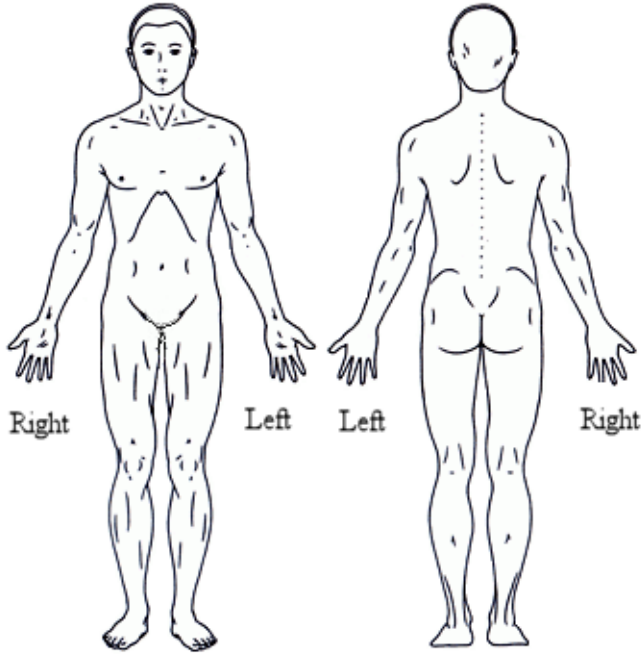
Is this condition progressively getting worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Using the symbols below, mark on the pictures where you feel pain.



Numbness == =

Dull Ache OOO

Burning XXX

Sharp/Stabbing ///

Pins, Needles + + +

Other _____ ^ ^ ^

Please mark any of the following conditions or symptoms that you have now or have experienced:

Other Symptoms:

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in Hands or Arms | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Hands or Arms | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pain in Legs or Feet | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Numbness in Legs or Feet | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Depression | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Sinus | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Heartburn/Reflux |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Allergies | <input type="checkbox"/> Loss of Smell or Taste |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Jaw/TMJ Problems | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Menopause |

Are you under medical care for any condition? _____

What Medications are you taking? _____

How long? _____ Have you had surgery? _____ What? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

Females Only – Date last Menstrual Period began on _____ Are you possibly Pregnant? _____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient Signature _____ Date _____