Patient History

Date: _____
Name: _____ Referred by: _____
Address: _____ City: _____ State: ____ Zip: _____ Phone: _____
Birthday: _____ Sex: _____ Age: _____ Martial Status: _____ # of Children: _____
Occupation: _____Employment: _____ Work phone #: _____
Social Security Number: _____ Drivers License #: _____
Please fill in the appropriate spaces (All information you give is confidential):
MAJOR COMPLAINT: _____
_____
How long have you had this condition? _____
Date began: _____
Have you lost work days: Yes( ) No ( ) How Many?_____
Have you had similar condition before? Yes( ) No ( ) When? _____
Was the injury related to: Work ( ) Auto accident ( )
When did you last see a chiropractor? _____ Dr.: _____
Why did you see this chiropractor?_____ Were you helped?_____
What spinal maintenance programs were you given to follow to maximize the future stability of your spine? ___
_____
Did you follow it? _____ If not, why? _____
Why are you changing chiropractors? _____

Past (O) or Present (X) Conditions:

____Fractures Bones
____Auto Accidents
(a) ____0-1 years ago
(b) ____1-5 years ago
(c)_____more than 5 years ago
____Other accidents/ Falls
____Knocked Unconscious
____Back Curvature
____Mental or Emotional Disorders
____Arthritis
____Diabetes
____Swollen or Painful Joints
____Convulsion/ Epilepsy
____Skin Problems
____Itching
____Bruised easily
____Cancer
____Frequent Cold/Flues
____Nervous
____Tension
____Depression
____Irritable
____Anemia
____Excess sweating
____Tremors
____Light Bothers Eyes
____Allergy
____Sinus Problems
____Light Headed Upon Rising
____Under Stress
____Crave Sweets or Salt
____Eating Disorder Trouble
____Sleeping
____Trouble concentrating

____Learning disability
____Mistake Sidedness R. L.
____Dyslexia
____Mood Changes
____Lose Temper Easily
____Headaches
____Neck pain or Stiffness R. L.
____Numbness, tingling, or pain in arms, Hands, fingers R. L.
____Jaw Pain or Click (T.M.J.) R. L.
____Head seems too heavy
____Head & shoulders feel tired
____Difficulty in excessive (standing, Walking, sitting, riding, bending, Lifting, twisting, household duties)
____Shoulder pain R. L.
____Dizziness
____Ringing in ear R. L
____Hearing Loss R. L.
____Fainting
____Loss of balance
____Blurred or double vision
____Upper back pain or stiffness R. L.
____Mid back pain or Stiffness R. L.
____Lower back pain or stiffness R. L.
____Numbness tingling or pain in buttocks thighs, legs =, feet, toes R. L.
____Chest pain
____Pain with cough, sneeze or strain at stools
____Hip pain R. L.
____Foot Trouble R.L.
____Asthma
____Lung problems

____Wheezing
____Heart problems \stroke
____Stroke
____High or low blood pressure
____Varicose veins
____Liver problem
____Gall bladder trouble
____Digestive problems
____Excessive gas
____Belching problems
____Heartburn
____Ulcers
____Diarrhea/constipation
____Colon trouble
____Hemorrhoids
____Prostate problems
____Impotence
____Kidney trouble
____Kidney stones
____Frequent urination
____Discharge
____Menstrual problems/PMS
____Menopause problems
____Breast, limps, sureness, discharge
____Pregnant (now)
____Bedwetting
____Ear infections
____Hepatitis
____Venereal disease
____AIDS/HIV
_____
_____
_____

What is your Health Philosophy (What Should you do to be Healthy?) _____

_____

_____

How do you want us to handle your problem?

_____ Temporary Relief (Help the Symptoms but do not fix the cause of the problem)

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

Why did you come into our clinic and what are you expectations of us?

_____

_____

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?

What surgeries have you had? _____

List drugs you now take (prescription and non-prescription): _____ _____

_____

Name other doctors you have seen for this condition: what was done, and for how long?

_____

_____

Are you currently wearing: Heel Lifts ( ) Arch Supports ( )

_____

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

Signature _____

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