Patient History (Please Print)

Date: _____

Name: _____ Email: _____
Phone: (Home) _____ (Mobile) _____ (Work) _____
Address: _____ City: _____ Zip: _____
Birth Date: ____/____/_____ □ Male □ Female Spouse/Parent Name: _____
Are you Pregnant? □ YES □ NO Due Date:_____ Occupation:_____
How were you referred to our office? _____
If from the internet, name of search engine and key words used: _____
Have you ever had Chiropractic Care before? _____ If yes, when? _____

Is this injury related to a work injury or automobile accident? □ Yes □ No
Have you reported the injury to your employer? □ Yes □ No
PLEASE NOTIFY THE FRONT OFFICE TEAM TO LET THEM KNOW YOU WERE INJURED AT WORK OR AUTOMOBILE ACCIDENT.

Do you have any health insurance? □ Yes □ No
Name of PCP_____Phone_____
PLEASE GIVE YOUR HEALTH INSURANCE CARD TO THE FRONT OFFICE TEAM IF YOU HAVE HEALTH INSURANCE
List your chief complaints in order of severity; Check all those that describe your condition:

Complaint 1: _____ For How Long? _____
What originally caused this problem? _____
Feels Like:
□ Sharp □ Throbbing □ Shooting □ Cramps □ Stiffness □ Dull Ache □ Numb/Tingling
□ Burning □ Other: _____
Bothers Me:
□ Constant (100%) □ Frequent (50%-75%) □ Intermittent (25%-50%) □ Occasional (1%-25%)
It Has Been:
□ Getting Worse □ Staying Same □ Getting Better
Pain Scale: (0=No Pain – 10=Severe Pain)
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
The Following Increases Pain:
□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____
The Following Decreases Pain:
□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____
Does The Pain Travel/Radiate? :
□ Yes □ No If yes, where_____ to _____

Complaint 2: _____ For How Long? _____
What originally caused this problem? _____
Feels Like:
□ Sharp □ Throbbing □ Shooting □ Cramps □ Stiffness □ Dull Ache □ Numb/Tingling
□ Burning □ Other: _____
Bothers Me:
□ Constant (100%) □ Frequent (50%-75%) □ Intermittent (25%-50%) □ Occasional (1%-25%)
It Has Been:
□ Getting Worse □ Staying Same □ Getting Better
Pain Scale: (0=No Pain – 10=Severe Pain)
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
The Following Increases Pain:
□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____
The Following Decreases Pain:
□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____
Does The Pain Travel/Radiate? :
□ Yes □ No If yes, where_____ to _____

List other doctors consulted for condition:

1: _____ 2: _____

3: _____ 4: _____

Does your condition interfere with any of the following:

- □ Computer Use
- □ Sports
- □ Reading
- □ Exercise
- □ Vacuuming
- □ Social Life
- □ Cleaning
- □ Cooking
- □ Watching Kids
- □ Yard Work
- □ Driving
- □ Relationship
- □ Shopping
- □ Gardening
- □ School
- □ Self Care
- □ Other: _____

Family History (please list all known conditions/illnesses that may apply):

Mother: _____ Father: _____

Grandparents: _____ Siblings: _____

Other known familial conditions: _____

Social History:

Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Widowed _____.

Children: No ____ Yes ____ How Many? _____.

Use of Alcohol: None____ Yes ____ How Much and Often? _____.

Use of Tobacco: Never ____ Quit____ Yes ____ How Much and Often? _____.

List of Current Medications/Supplements:

_____

_____

_____

List of Previous Hospitalization / Surgeries / Traumas / Falls / Auto Accidents:

_____

_____

_____

Is there anything else you think we should know about or that you would like to discuss? (Explain):

_____

_____

Authorization and Release

I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services I may need and release information to others if necessary for my care.

Patient's Signature: _____ **Date:** _____

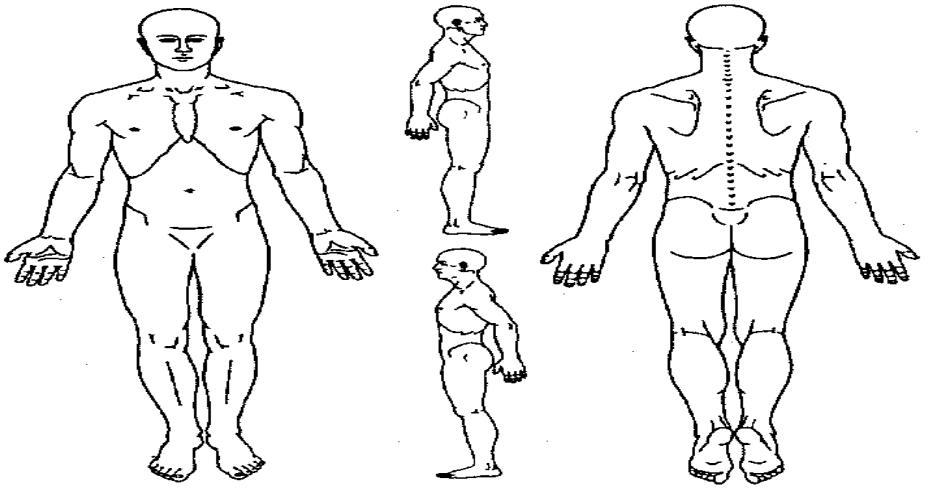
***** If you have insurance please give the front desk your card *****

Review of Systems

Gastrointestinal		
Uncontrollable Bowels	No	Yes
Nausea	No	Yes
Vomiting	No	Yes
Heartburn	No	Yes
Black Stool	No	Yes
Red blood in stool	No	Yes
Abdominal pain	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Loss of appetite	No	Yes
Bloating	No	Yes
Constitutional		
Cancer	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Recent weight gain	No	Yes
Recent weight loss	No	Yes
Pain at night	No	Yes
Genitourinary		
Frequent urination	No	Yes
Kidney failure/dialysis	No	Yes
Uncontrolable Bladder	No	Yes
Neurological		
Seizures	No	Yes
Headaches	No	Yes
Dizziness	No	Yes

HEENT		
Sore throat	No	Yes
Hoarseness	No	Yes
Cardiovascular		
Stroke / TIA	No	Yes
Heart Attack	No	Yes
Abnormal heart rhythm	No	Yes
Chest pain	No	Yes
High Blood Pressure	No	Yes
Peripheral Vascular Disease	No	Yes
Respiratory		
Cough	No	Yes
Shortness of breath on exertion	No	Yes
Shortness of breath at rest	No	Yes
Wheezing	No	Yes
Dermatology		
Rash	No	Yes
Endocrine		
Diabetes	No	Yes
Thyroid Disease	No	Yes
Musculoskeletal		
Joint pain	No	Yes
Arthritis	No	Yes
Arthritis Type _____.		

Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels. Include all affected areas.



I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. To the best of my knowledge, t questions on these forms have been accurately answered.

Went over ROS with patient Dr signature:_____

Patient Signature: _____ **Date:**_____