

## Patient History

Date \_\_\_\_\_ E-mail \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Permanent address (if different from above) \_\_\_\_\_

SS# \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Spouse \_\_\_\_\_

Children \_\_\_\_\_ Who is responsible for this bill?  Self  PI  INS  Medicare

**Who referred you to our office?** \_\_\_\_\_

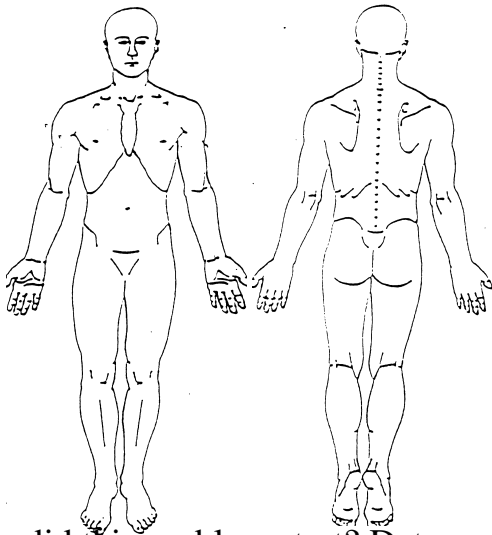
*Chief Complaint:* Headaches Neck pain Midback Lowback Arm Leg Shoulder

(Red ink indicates Dr.'s notes) Other \_\_\_\_\_

Pain radiates from \_\_\_\_\_ to \_\_\_\_\_ and from \_\_\_\_\_ to \_\_\_\_\_

### Pain Diagram:

Place the (letter) of the complaint on the diagram to indicate your area of pain.



Pain (P)

Tingling (T)

Numbness (N)

Burning (B)

Stiffness (S)

Notes: \_\_\_\_\_

\_\_\_\_\_

When did this problem start? Date: \_\_\_\_\_ (circle) Gradual Sudden Progressive

If this is a recurrence, when was the first time you noticed this problem? \_\_\_\_\_

Is this complaint injury related? Yes No Work Auto

Explain: \_\_\_\_\_

Severity of Problem: (circle) 0 1 2 3 4 5 6 7 8 9 10

(How do you feel?) Best Worst

Is the Pain?(circle) Constant Frequent Intermittent Occasional

Pain character: Dull/Ache Sharp/Stabbing Burning Numbness/Tingling Throbbing

Other: explain \_\_\_\_\_

Relation to other body systems or parts: Bowel or Bladder Other \_\_\_\_\_

Relieving Factors: Rest Exercise Sitting Standing Lying down Hot Packs Cold Packs

Aggravating Factors: Coughing Sneezing Lifting Bending Pushing Pulling Driving Riding  
Sitting Standing Walking Running Other: \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

Have you seen another health care professional for this problem? Explain: \_\_\_\_\_

**TREATMENT: What type of treatment are you looking for?**

- I am looking for the most minimal amount of care to “patch up the symptoms.”
- I am looking to resolve my symptoms and then go on to “fix the cause” of my problem.
- I am looking to take care of my problem and then go on to “achieve optimal health and wellness.”

**Any history of the following throughout your lifetime:**

Past Illnesses/Diseases \_\_\_\_\_

Medications/Any type of Surgeries/Scars \_\_\_\_\_

Previous Accidents or Injuries \_\_\_\_\_

Previous Car Accidents? \_\_\_\_\_ What was injured? \_\_\_\_\_

Have you ever been to a chiropractor for this before? \_\_\_\_\_

Have you seen a Chiropractor for anything? \_\_\_\_\_ Other Problems? \_\_\_\_\_

Do you have any of the following symptoms?

Headaches  Irritability  Chest pain  Shortness of breath  Buzzing in ears  Dizziness  
 Fatigue  Loss of balance  Sleeping problems  Depression  
 Fainting spells  Constipation  Light bothers eyes  Loss of smell  Loss of taste  
 Cold sweats  Nervousness  Loss of memory  Fever  Tension  Ears Ringing  
 Diarrhea  Other: \_\_\_\_\_

Have you lost any time from work or other activities as a result of this condition?

Yes From \_\_\_\_\_ To \_\_\_\_\_  No

Have you ever suffered a stroke?  Yes  No

Has anyone in your family suffered a stroke?  Yes  No Who \_\_\_\_\_

Have you ever suffered a heart attack?  Yes  No

Has anyone in your family suffered a heart attack?  Yes  No Who \_\_\_\_\_

Do you have any know vascular disease?  Yes  No

Does anyone in your family have vascular disease?  Yes  No Who \_\_\_\_\_

Do you smoke?  Yes  No How much do you smoke? \_\_\_\_\_ How long?

Have you ever smoked in the past?  Yes  No

Do you take birth control pills?  Yes  No How long? \_\_\_\_\_

Signature: \_\_\_\_\_

(Dr.'s Notes)

Water: \_\_\_\_\_ per day Caffeine \_\_\_\_\_ per day Work \_\_\_\_\_

VIT: \_\_\_\_\_ DIET: \_\_\_\_\_ Alcohol \_\_\_\_\_