

# CONFIDENTIAL PATIENT HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone (H) \_\_\_\_\_ Soc Sec Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Phone (Work or cell) \_\_\_\_\_ E-mail address \_\_\_\_\_  
Marital Status S M D W Number of Children \_\_\_\_\_ Have you been here before? Y N When? \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Years there \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone (W) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
How did you hear about this office? \_\_\_\_\_

Are you covered by Medicare? Y N Are you covered by State Insurance Aid? Y N  
Do you have group, union or other personal health insurance? Y N

**What is your major complaint?** \_\_\_\_\_

How long have you had this? \_\_\_\_\_ Have you had this before? Y N When? \_\_\_\_\_

Have you missed work? Y N How long were you out of work? \_\_\_\_\_

Other complaints: \_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_

Is this condition getting worse? Y N Is this problem constant or does it come and go? \_\_\_\_\_

How long since you really felt good? \_\_\_\_\_

List date and type of surgeries or hospitalizations \_\_\_\_\_

Smoking Status: [ ] Never Smoker [ ] Former Smoker [ ] Current-Sometimes Smoker [ ] Current-Everyday Smoker

Do you have any medication allergies? Y N What? \_\_\_\_\_

Are you currently taking any medication? Y N What mg? \_\_\_\_\_

What non-prescription drugs, vitamins or supplements are you taking? \_\_\_\_\_

Other doctors seen for this condition \_\_\_\_\_

Family doctor \_\_\_\_\_ Practice Name/Location \_\_\_\_\_ / \_\_\_\_\_

Date of last visit \_\_\_\_\_ For what? \_\_\_\_\_ May I send an initial report of my findings? YES or NO

Have you ever seen a Chiropractor? Y N Who? \_\_\_\_\_ For what? \_\_\_\_\_

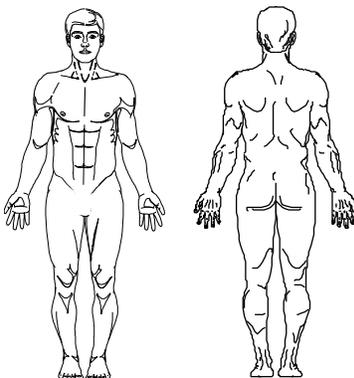
Date of last visit to a Chiropractor \_\_\_\_\_ Date of last x-rays by a Chiropractor \_\_\_\_\_

Do you have a pacemaker? Y N Do you have now or have ever had any type of cancer? Y N

Do you have now or have ever had any type of infection? Y N

Are you pregnant or think you might be pregnant? Y N

**Please use the pictures below and mark your problem areas with an X.**



All of the above information is true and correct. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment for any reason, any fees for professional services rendered to me will be immediately due and payable.

**Patient's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

Please check (X) EVERYTHING that you have EVER had - now OR in the past. Circle L, R, or B for Left, Right, or Both

**HEAD**

- Sinus (allergy) headache
- Entire head headache
- Back of head headache
- Forehead headache
- Side of head (temple) headache (L - R - B)
- Migraine headache
- Head feels heavy
- Loss of memory
- Light-headedness
- Fainting
- Light bothers eyes
- Blurred vision
- Double vision
- Loss of vision (L - R - B)
- Loss of taste
- Loss of balance
- Loss of hearing (L - R - B)
- Pain in ears (L - R - B)
- Ringing in ears (L - R - B)
- Buzzing in ears (L - R - B)
- Dizziness

**NECK**

- Pain in neck
- Neck pain with movement
- Bending head forward
- Bending head backward
- Turning head to the left
- Turning head to the right
- Bending head to the left
- Bending head to the right
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasm in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

**SHOULDERS**

- Pain in shoulder joint (L - R - B)
- Pain across shoulders
- Bursitis in shoulder (L - R - B)
- Arthritis in shoulder (L - R - B)
- Can't raise arm above shoulders (L - R - B)
- Can't raise arm over head (L - R - B)
- Tension in shoulders (L - R - B)
- Pinched nerve in shoulder (L - R - B)
- Muscle spasm in shoulders (L - R - B)

**ARMS & HANDS**

- Pain in upper arm (L - R - B)
- Pain in elbow (L - R - B)
- Moving aggravates the pain
- Tennis elbow (L - R - B)
- Pain in forearm (L - R - B)
- Pain in hands (L - R - B)
- Pain in fingers (L - R - B)
- Pins & needles in arms (L - R - B)
- Pins & needles in fingers (L - R - B)
- Arms are numb / go to sleep (L - R - B)
- Fingers are numb / go to sleep (L - R - B)
- Hands cold (L - R - B)
- Arthritis/swelling in hands/fingers L - R - B)
- Loss of grip strength (L - R - B)

**MIDDLE BACK**

- Middle Back Pain
- Pain between shoulder blades
- Pain from front to back
- Muscle spasms
- Pain in kidney area (L - R - B)

**CHEST**

- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Dimpled or orange peel breast
- Irregular heartbeat

**ABDOMEN**

- Nervous stomach
- Can't eat certain foods
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

**LOW BACK**

- Upper low back pain
- Lower low back pain
- Sacroiliac (SI) or hip pain (L - R - B)
- Slipped, bulging or herniated disk
- Low back feels out of place
- Muscle spasm
- Arthritis

**HIPS, LEGS & FEET**

- Pain in buttocks (L - R - B)
- Pain in hip joint (L - R - B)
- Pain down leg (L - R - B)
- Knee pain (L - R - B)
- Leg cramps (L - R - B)
- Foot cramps (L - R - B)
- Pins & needles feeling (L - R - B)
- Numbness in leg (L - R - B)
- Numbness in foot (L - R - B)
- Numbness in toes (L - R - B)
- Cold feet (L - R - B)
- Swollen feet (L - R - B)
- Swollen ankle (L - R - B)
- Arthritis

**WOMEN ONLY**

- Menstrual pain
- Cramping
- Irregularity
- Cycle \_\_\_\_\_ days
- Birth control type \_\_\_\_\_
- Hysterectomy

**MEN ONLY**

- Trouble starting urination
- Excessive night urination
- Prostate pain or swelling
- Frequent urination

**GENERAL**

- Nervousness
- Irritable
- Depressed
- Fatigue
- Generally feel run-down
- Normal sleep \_\_\_\_\_ hours
- Loss of sleep \_\_\_\_\_ hours
- Loss of weight \_\_\_\_\_ pounds
- Gain weight \_\_\_\_\_ pounds
- Coffee \_\_\_\_\_ cups per day
- Tea \_\_\_\_\_ cups per day
- Cigarettes \_\_\_\_\_ pack per day
- Diabetes
- Hypoglycemia

**MY PAIN IS WORSE WHEN:**

- Working
- Lifting
- Stooping
- Standing
- Sitting
- Bending
- Coughing
- Lying down (sleeping)
- Walking
- Other \_\_\_\_\_

**MY PAIN IS BETTER WHEN I:**

- Rest
- Use ice
- Use heat
- Stretch
- Move around
- Work
- Stand
- Sit
- Get adjusted by a Chiropractor
- Get it massaged
- Lay down
- Walk
- Take drugs: \_\_\_\_\_
- Rub on a cream / salve / ointment
- Take time off of work
- Other: \_\_\_\_\_

**OTHER REMARKS BELOW:**

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