

PATIENT HISTORY FORM

Please fill out the following form with as much detail as possible.

First Name: _____ Last Name: _____

REASON FOR YOUR VISIT:

Cause of complaint: Auto Accident _____ Work Injury _____ Athletic Injury _____ Other Injury: _____

Are you or do you think you may be pregnant? Yes _____ No _____

Have you seen a chiropractor before? Yes _____ No _____ When? _____ Doctor's Name _____

Describe your major complaint: _____

What movements, positions, or activities aggravate this condition? Standing _____ Walking _____ Sitting _____
Lying down _____ Bending _____ Lifting _____ Twisting _____ Coughing _____

Are the symptoms: Improving _____ Getting worse _____ About the same _____ Intermittent _____

Have you been treated for this condition before? Yes _____ No _____ If yes, when? What was done? _____

Date when the symptoms first appeared: _____

Circle most appropriate:

What is your pain Right Now? 0 = NO PAIN - 10 = UNBEARABLE PAIN 0 1 2 3 4 5 6 7 8 9 10

PATIENT HEALTH HISTORY

Family History (Please check as many as apply)

Mother:

Cancer _____ Heart Disease _____ High Blood Pressure _____ Diabetes _____ Respiratory Problems _____
Kidney _____ Stroke _____ Arthritis _____ Good Health _____ If deceased - Age of Death _____

Father:

Cancer _____ Heart Disease _____ High Blood Pressure _____ Diabetes _____ Respiratory Problems _____
Kidney _____ Stroke _____ Arthritis _____ Good Health _____ If deceased - Age of Death _____

Siblings:

Cancer _____ Heart Disease _____ High Blood Pressure _____ Diabetes _____ Respiratory Problems _____
Kidney _____ Stroke _____ Arthritis _____ Good Health _____ If deceased - Age of Death _____

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SOCIAL HISTORY

Do you exercise: Daily ___ Regularly ___ Occasionally ___ Never ___

Do you eat a balanced diet? Yes ___ No ___

How many hours do you sleep? ___

Do you smoke? No ___ Yes ___ How many packs a day _____

Do you drink alcohol No ___ Yes ___ How often _____

MEDICAL HISTORY

Personal History:

Illness or Conditions _____

Surgeries _____

Fractures _____ Previous Injuries _____

Medications _____ Supplements _____

Last Medical Exam (dd/mm/yy) _____

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SYMPTOMS

Have you had or do you have any of the following symptoms: (check all that apply)

Headaches	_____	Frequent Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping	_____	Loss of Taste	_____
Back Pain	_____	Pain with Bowel Movement	_____
Nervousness	_____	Diarrhea	_____
Tension	_____	Cold Feet	_____
Irritability	_____	Cold Hands	_____
Chest Pains	_____	Arthritis	_____
Dizziness	_____	Muscle Spasms	_____
Shoulder/Neck Pain	_____	Frequent Colds	_____
Pins & Needles Arms	_____	Stomach Upset	_____
Pins & Needles Legs	_____	Constipation	_____
Numbness in Toes	_____	Cold Sweats	_____
Sinus Problems	_____	Numbness in Fingers	_____
Diabetes	_____	High Blood Pressure	_____
Buzzing in Ears	_____	Difficulty Urinating	_____
Leg Cramps	_____	Allergies	_____
Colitis	_____	Weakness in Arms	_____
Gall Bladder	_____	Weakness in Legs	_____
Indigestion	_____	Shortness of Breath	_____
Belching	_____	Fatigue	_____
Vomiting	_____	Depression	_____
Shoulder Pain	_____	Does Light Bother Eyes	_____
Swelling Joints	_____	Loss of Memory	_____
Knee Pain	_____	Ears Ring	_____
Hay fever	_____	Face Flushed	_____

Use this space for any additional information you may wish to discuss: _____
