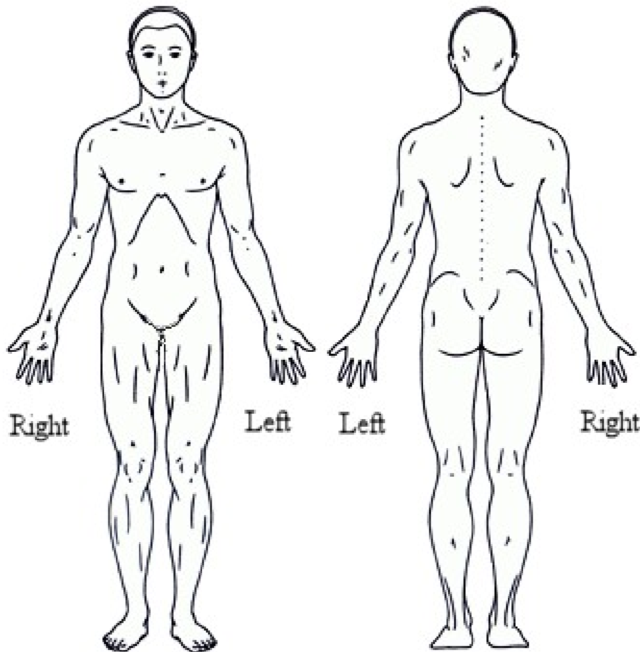
Patient History

Name____________________ Date____________
Address____________________ State________ Zip________
H. Phone (______)____________ W. Phone__________ Date of Birth________ Age________
Referred by____________________ Social Security #____________________
Occupation____________________ Employer____________________
Marital Status S M D W Spouse Name____________________
Number of Children/Ages____________________ Spouses Occupation____________________
Have you ever received Chiropractic Care? Yes No

Please circle for each of the following:		Patient Comment If answer is Yes	Chiropractor's Comments
1. Regarding your Birth Process:			
Was the delivery long/difficult?	Y N	______	______
Forceps or extraction used?	Y N	______	______
Cesarean/ C-Section?	Y N	______	______
Breach/ cephalic?	Y N	______	______
Home birth?	Y N	______	______
Hospital birth?	Y N	______	______
Mother given drugs during delivery?	Y N	______	______
Was labor induced?	Y N	______	______
2. Growth and Development/ Childhood:			
Were you breast fed?	Y N	______	______
Health education?	Y N	______	______
Childhood illnesses?	Y N	______	______
Ear infections/ Colic/ Asthma?	Y N	______	______
Attention Deficit?	Y N	______	______
Antibiotics?	Y N	______	______
Drugs, prescription, OTC, recreational?	Y N	______	______
Surgery?	Y N	______	______
Hospitalizations?	Y N	______	______
Sports or other physical activities	Y N	______	______
Injuries during sports?	Y N	______	______
Auto accidents?	Y N	______	______
Did you have other traumas?	Y N	______	______
Did you ever break any bones?	Y N	______	______
3. Current Health Habits:			
Did/do you smoke?	Y N	______	______
Did/do you drink alcohol?	Y N	______	______
Diet, do you eat healthy foods?	Y N	______	______
Have you been in accidents/trauma?	Y N	______	______
Have you had surgery?	Y N	______	______
Drugs, prescription, OTC, recreational?	Y N	______	______
Dental problems?	Y N	______	______
Eye problems?	Y N	______	______
Hearing problems?	Y N	______	______
Exercise regularly?	Y N	______	______
Did/do you have occupational stress?	Y N	______	______
Drive? Daily time spent driving	Y N	______	______
Physical stress?	Y N	______	______
Emotional/Mental stress?	Y N	______	______
Hobbies/Sports injuries?	Y N	______	______
Do you sleep well, hours of sleep?	Y N	______	______
Sleeping posture? O side O stomach O back		______	______

Symptoms and Present State of Health
Present Complaint/Reason for Seeking Care in this Office:
Major____________________
Pain or Problem started on____________________
Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other__________
Does this pain shoot, radiate, or travel in your body? Where?____________________
Are you experiencing numbness or tingling in any area of your body? Where?____________________
Since it began, is it: O Same O Better O Worst
What activities aggravate your condition/pain?____________________
What activities lessen your condition/pain?____________________

Is this condition worse during certain times of the day?____
Is this condition interfering with Work?__________ Sleep?__________Routine?_______Other?______________________
Is this condition progressively getting worse?____
Other Doctors seen for this condition____
Any home remedies? ____
Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Using the symbols below, mark on the pictures where you feel pain.



Numbness = = =

Dull Ache OOO

Burning XXX

Sharp/Stabbing / / /

Pins, Needles + + +

Other ______ ^ ^ ^

Please mark any of the following conditions or symptoms that you have now or have experienced:
Other Symptoms:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

Are you under medical care for any condition?____
What Medications are you taking?____
How long?________________ Have you had surgery?________________ What?________________ When?________________
What side effects have you experienced from the drugs and surgery?____
Females Only – Date last Menstrual Period began on________________________________ Are you possibly Pregnant?__________

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_________________
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.
Patient Signature____Date__________________________