

PATIENT HISTORY

My Main Complaint that made me seek care: _____

Any other Complaints: _____

How long have you suffered with this problem/initial onset? _____

What have you tried to do to get rid of this problem that DID NOT work? _____

Prior interventions: Prescription/OTC drugs Massage Homeopathy Chiropractic Physical therapy

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____

Intensity (how extreme are your overall symptoms)? 0 - - - - - - - - - 10
absent - uncomfortable - agonizing

How does this problem interfere with the following areas of your life?

WORK/CAREER: _____

FAMILY/HOUSEHOLD RESPONSIBILITIES: _____

HOBBIES/RECREATIONAL ACTIVITIES: _____

LIFE/PERSONAL RELATIONSHIPS: _____

Does handling this problem cause stress for you? _____

What do you do that makes this problem worse? _____

What gives you some temporary relief? _____

How much older does this makes you feel: _____

If we were able to find the cause of your problem and get rid of it, please rate your level of commitment in helping us do this (on a scale of 1 to 10, with 10 being the highest): _____

What is the pattern of this problem? Constant ____, Intermittent ____, Occasional ____, Cyclic ____

What is the effect it has on your body functions? _____

How did it start? _____

Could your problem have been caused by an injury at work? _____

If yes, please give us the details: _____

Are you making a claim against this work related injury/accident? Yes or No

Have you been involved in any auto accidents? _____ Date of accident (s): _____

Any difficulties from this? _____

Are you making a claim against this motor vehicle accident? Yes or No

Children's Name(s) and Age(s): _____

Do they have any health problems that you are aware of (growing pains, ear infections, asthma, allergies, colic, ADHD, etc)? _____

Is there any other information you would like the Doctor to know about your health/concerns? _____

What do you expect from your care at this office? _____

Draw in your face.
Show area(s) of pain or unusual feeling.
Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.
Mark areas of radiation. Include all affected areas.

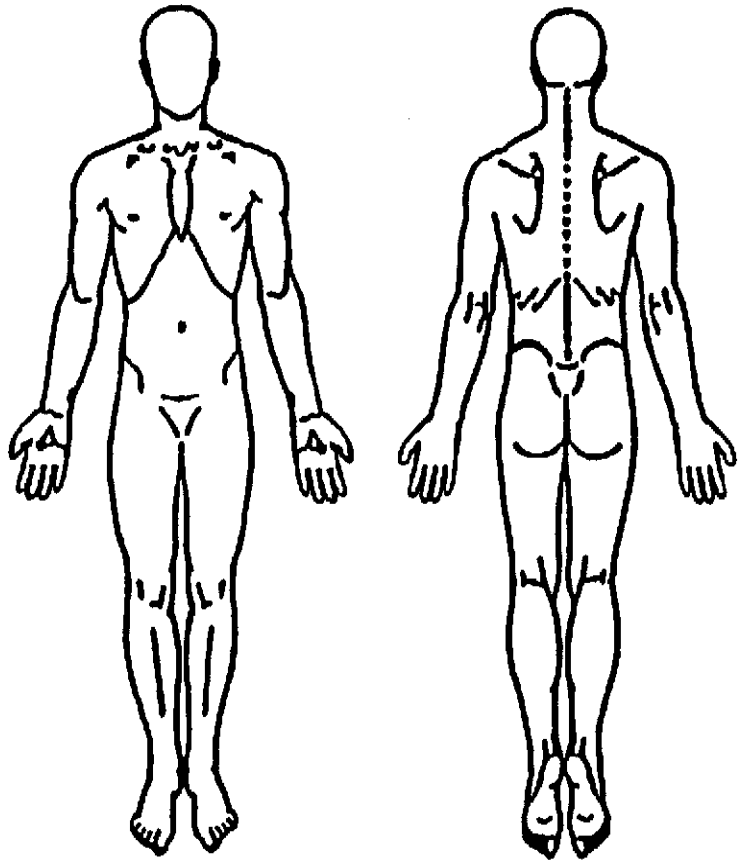
Numbness ● ● ● ● ●
 ● ● ● ● ●
 ● ● ● ● ●

Pins & Needles ○ ○ ○ ○ ○
 ○ ○ ○ ○ ○
 ○ ○ ○ ○ ○

Burning X X X X X
 X X X X X
 X X X X X

Aching * * * * *
 * * * * *
 * * * * *

Stabbing / / / / /
 / / / / /
 / / / / /



Have you ever had any of the following:

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | aneurysm | <input type="checkbox"/> | <input type="checkbox"/> | osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | diabetes (type <input type="checkbox"/> 1 or <input type="checkbox"/> 2) |
| <input type="checkbox"/> | <input type="checkbox"/> | arthritis | <input type="checkbox"/> | <input type="checkbox"/> | respiratory conditions | <input type="checkbox"/> | <input type="checkbox"/> | epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | cancer type: _____ | <input type="checkbox"/> | <input type="checkbox"/> | strokes | <input type="checkbox"/> | <input type="checkbox"/> | allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | heart conditions | <input type="checkbox"/> | <input type="checkbox"/> | hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | nerve problems |
| <input type="checkbox"/> | <input type="checkbox"/> | poor posture/scoliosis | <input type="checkbox"/> | <input type="checkbox"/> | polio | <input type="checkbox"/> | <input type="checkbox"/> | sleep apnea/difficulties |
| <input type="checkbox"/> | <input type="checkbox"/> | pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | psoriasis | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | V.D./STD's | <input type="checkbox"/> | <input type="checkbox"/> | sinus conditions | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Childhood conditions you had, please check:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> measles | <input type="checkbox"/> mumps | <input type="checkbox"/> chicken pox | <input type="checkbox"/> whooping cough |
| <input type="checkbox"/> scarlet fever | <input type="checkbox"/> diphtheria | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> typhoid fever |
| <input type="checkbox"/> ear infections | <input type="checkbox"/> tubes in ears | <input type="checkbox"/> chronic illness | <input type="checkbox"/> other: _____ |

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional (1-33% of the time)

F = Frequent (33-66%)

C = Constant (66-100%)

- | O | F | C | |
|--------------------------|--------------------------|--------------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | chills |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | fevers |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | migraines |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | loss of sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | nervousness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | depression |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | numbness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | sweats |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | loss of weight |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | tremors |

Muscle & Joint

- | | | | |
|--------------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | bursitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | carpal tunnel |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | mid back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | low back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | neck pain/stiffness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | TMJ issues |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | pain between shoulders |

Respiratory

- | | | | |
|--------------------------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | chronic cough |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | difficulty breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | spitting blood |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | throat phlegm |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | wheezing |

Eyes, Ears, Nose & Throat

- | | | | |
|--------------------------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | head colds |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | crossed eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | deafness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | dental decay |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ear aches/infections |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ear discharges |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ear noises/ringing |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | sinus infections |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | enlarged glands |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | enlarged thyroid |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | sore throat |

- | O | F | C | |
|--------------------------|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | tonsillitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | eye pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | failing vision |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | gum trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | hay fever |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | hoarseness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | nasal obstruction |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | near/far sighted |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | nosebleeds |

Cardio-Vascular

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | rapid heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | slow heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | swelling of ankles |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | hardening of arteries |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | high blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | pain over heart |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | poor circulation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | high cholesterol |

Gastro Intestinal

- | | | | |
|--------------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | excessive hunger |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | burping or gas |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | liver trouble/jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | colon trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | difficult digestion |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | acid reflux/heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | crohn's |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | stomach pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | gall bladder trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | hemorrhoids |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | irritable bowel |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | poor appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | vomit blood |

Skin

- | | | | |
|--------------------------|--------------------------|--------------------------|---------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | acne |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | bruise easily |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | dryness |

- | O | F | C | |
|--------------------------|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | hives or allergy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | itching |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | skin rash |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | varicose veins |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | eczema |

Genito-Urinary

- | | | | |
|--------------------------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | bed wetting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | lose bladder control |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | kidney infection |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | painful urination |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | prostate trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | pus in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | smell of urine |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | sterility problems |

Pain or Numbness in:

- | | | | |
|--------------------------|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | shoulders |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | arms/elbows |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | hands/wrists |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | hips |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | legs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | knees |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ankles |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | feet |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | painful tail bone |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | sciatica |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | swollen joints |

For Women Only:

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | heavy flow |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | light flow |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | irregular cycle |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | painful cycle |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | sore breasts |

Menopausal: Yes No

Pregnant: Yes No

Due Date: _____

Habits of Lifestyle

Do you smoke? Yes No
Do you consume alcohol? Yes No
Do you exercise? Yes No
Exercise Indoor Activities: _____
Exercise Outdoor Activities: _____

Rate your sleep hours per night: 4-6 6-8 8-10 12+ Do you wake rested? Yes No

Rate your appetite: Poor Fair Medium Good Excellent
Rate your diet: Poor Fair Medium Good Excellent
Do you eat regularly: Breakfast Lunch Dinner
Do you eat per day: 1 meal 2 meals 3 meals 4 meals More than 4 meals
How much water do you drink/day? _____ Soda? _____ Coffee? _____
Date of last dental examination: _____

Falls (please list any major or minor falls in your life, i.e. slipping on ice, sports, work related): _____

Approximately what percentage of your day do you spend sitting? _____ %

Surgery/Operations (please list): _____

Surgery recommended but not performed (please list): _____

Do you take vitamins and minerals? Yes No List: _____

Have you ever been knocked unconscious: Yes No Don't Know If so, for how long: _____

List any medication or drugs you are currently taking and what they are for (ie. Lipitor for high cholesterol): _____

Have you previously been hospitalized: Yes No Reasons: _____

Any family health conditions: Yes No Please list: _____

Acknowledgements:

To set clear expectations, improve communications and help you get the best results in the appropriate amount of time, please read each statement and initial agreement.

Initials _____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I may be adjusted in a semi-private room where private information I offer may be overheard by others. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct spinal misalignments/nerve stress (vertebral subluxations). Chiropractic is a separate healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved parties.

Initials _____ I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YY): _____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern(s).

Signature: _____ Date: _____