

CHIROPRACTIC PATIENT HEALTH HISTORY

Please complete this questionnaire. Your answers will help us determine how Chiropractic can help you.

NAME: _____ **INITIAL VISIT DATE:** _____

Address: _____ **City:** _____ **Postal Code:** _____

Please check your preferred method(s) of contact Cell Phone #: _____

Home Phone #: _____ Email - home: _____

Work Phone #: _____ Email - work: _____

Birthdate (M/D/Y): _____ **Sex:** M / F **Ht:** _____ **Wt:** _____ **Family Dr:** _____

Occupation: _____ **Employer:** _____

How did you hear about us? Y Pgs Internet Referral: _____ Other: _____

Have you had Chiropractic care before? No Yes **Dr.** _____ **Last visit:** _____

Have you ever had "Spinal" x-rays taken? No Yes **Reason:** _____ **Date:** _____

Other "Diagnostic Imaging": MRI CT Ultrasound Other **Date:** _____ **Location:** _____

Please check off all current or previous conditions:

Current/Previous	Current/Previous	Current/Previous	Current/Previous
GENERAL SYMPTOMS	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Chest pain on activity	GASTROINTESTINAL
<input type="checkbox"/> Headaches	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Previous stroke	<input type="checkbox"/> Poor appetite
<input type="checkbox"/> Migraines	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hardening of arteries	<input type="checkbox"/> Difficult digestion
<input type="checkbox"/> Fever	<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Excessive hunger
<input type="checkbox"/> Chills	<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Belching
<input type="checkbox"/> Sweats	<input type="checkbox"/> Enlarged thyroid	MUSCLE & JOINT	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Fainting	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Neck ache	<input type="checkbox"/> Nausea
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Sinus infection	<input type="checkbox"/> Back ache	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Seizures	<input type="checkbox"/> Enlarged glands	<input type="checkbox"/> Swollen joints	<input type="checkbox"/> Stomach pain
<input type="checkbox"/> Convulsions	SKIN	<input type="checkbox"/> Painful tailbone	<input type="checkbox"/> Constipation
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Itching	<input type="checkbox"/> Foot pain	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Rashes	<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Flatulence
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Bruising easily	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Loss of Weight	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Hernia	<input type="checkbox"/> Liver trouble
<input type="checkbox"/> Numbness or tingling	<input type="checkbox"/> Sensitive skin	<input type="checkbox"/> Spinal curvature	<input type="checkbox"/> Gallbladder trouble
<input type="checkbox"/> In arms, legs, hands	<input type="checkbox"/> Hives	<input type="checkbox"/> Faulty posture	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Allergies	RESPIRATORY	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Colitis
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Chronic cough	GENITOURINARY	WOMEN ONLY
E.E.N.T.	<input type="checkbox"/> Spitting up phlegm	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Painful Menstruation
<input type="checkbox"/> Failing vision	<input type="checkbox"/> Chest pain with breathing	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Excessive flow
<input type="checkbox"/> Near sighted	<input type="checkbox"/> Difficult breathing	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Far sighted	CARDIOVASCULAR	<input type="checkbox"/> Kidney infection	<input type="checkbox"/> Irregular cycle
<input type="checkbox"/> Eye pain	<input type="checkbox"/> Rapid heart beat	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Cramps or backache
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Slow heart beat	<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Congested breast
<input type="checkbox"/> Earache	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Bladder incontinence	<input type="checkbox"/> Lumps in breast
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Previous pregnancy
<input type="checkbox"/> Nosebleeds			

Have you ever had any of the following diseases/conditions?

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Measles	<input type="checkbox"/> Anemia	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rubella	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Malaria	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Rheumatoid Arthritis	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Polio	<input type="checkbox"/> Gout	_____
<input type="checkbox"/> Stroke	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Shingles	<input type="checkbox"/> Influenza	<input type="checkbox"/> Psoriasis	_____
<input type="checkbox"/> Mumps	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Scarlet Fever		

Has anyone in your family had any of the following diseases/conditions?

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Gout	<input type="checkbox"/> Spinal Surgery
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Other (Specify): _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Low Back Pain	_____
<input type="checkbox"/> Stroke	<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Disc Disease	_____

Smoker: No Yes - How long? _____ **Pregnant:** No Yes - How many weeks? _____

Medications/Supplements you currently take: _____

Surgeries you have had in the past: _____

CONFIDENTIAL CASE HISTORY

PATIENT NAME: _____ **DATE:** _____

What is your **Primary Complaint?** _____

Describe the **Location** of your **symptoms:** _____

How long has this problem bothered you? _____

How often does it bother you? Constantly Daily Weekly ___x /wk Monthly ___x / month

Does this problem **refer** to other areas? **Yes** **No** Where? _____

Has this problem been progressively getting **better** or **worse** **staying the same** over time?

What is the **level of your pain** at its **worst?** (**0** = No pain - **10** = Worst pain of my life) _____

What is the **level of your pain** at its **best?** (**0** = No pain - **10** = Worst pain of my life) _____

What is the **Character (Quality)** of your pain? Dull/ache Sharp/stabbing Burning Shooting
 Pinching Numbness / tingling Variable Other _____

What **aggravates** your condition? _____

What **relieves** your condition? _____

What **other treatment** have you tried for this condition?

Rest Ice/Heat Stretches Physiotherapy Acupuncture Massage Other _____

What **activities** does this **prevent** you from doing? _____

Does this problem cause you to experience any **sleep problems?**

Difficulty falling asleep Waking during the night Waking earlier than normal Waking unrested

Please list any **other complaints** (health problems) you would **like to get rid of:**

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Is there anything **preventing** you from getting your problem(s) taken care of? Yes No

Do you have any **Concerns?** None Time Transportation Cost Other _____

What are your **goals for care?** Pain/symptom relief Improved function Correction of the "Cause"
 Maintenance & Prevention of other problems Overall Health & Wellness

Have you ever had any major **falls?** Down the stairs On ice Off Bikes From trees
 Other _____

Have you ever had any **Sports injuries?** Sprain/Strain Fracture Concussion Dislocation
 Other Describe: _____

What type of **sleep posture** do you have? Belly Side Back More than 1 pillow Futon/Waterbed

What type of **Physical stress** do you have at home/work? Heavy lifting Repetitive strain
 Overhead work Prolonged sitting/standing Computer/desk work Other _____

Have you ever been involved in any **motor vehicle accidents** (minor or major)? Yes No

1. **Date**(year): _____ **Injuries/Treatment:** _____

2. **Date**(year): _____ **Injuries/Treatment:** _____