VERNE CHIROPRACTIC CLINIC, PA
Dr. Michael H. Verne, D.C., CSCS
467 Lake Howell Road Suite #204, Maitland, FL 32751
Office (407) 657-2225 Fax (407) 657-2220

Patient Health History

(Please print and fill out form completely)

Name: _____ **Today's Date**:_____
First Last Middle Initial

Address:_____Apt#_____

City:_____ **ST:**_____ **Zip:**_____

Phone #: ( )_____ ( )_____( )_____
Home Cell Work

Birth Date: _____/_____/_____ **Age**:_____ **Email:**_____

SS #:_____ ☐ **Male** or ☐ **Female** Female: Are you pregnant? Yes No

Do you have breast implants? Yes No

Marital Status: (Circle One) Married Single Widowed Divorced

Spouse's Name:_____ **# of Children:** _____

Your Employer:_____ Occupation:_____

Type of work Duties:_____

Emergency Contact:_____ Phone #:_____

How did you hear of our office? _____

What hobbies do you enjoy when you are feeling good? _____

What position do you sleep in? _____ Do you exercise? _____

Have you had previous chiropractic care? □ No □ Yes, name of previous chiropractor:_____

Last date of care:_____ What did they do? _____

Reason for consulting previous chiropractor:_____

Were you happy with previous results? _____

Social History

Tobacco use: □ Never a smoker □ Former smoker □ Current heavy smoker □ Current light smoker

Alcohol use:	□ Never	□ Occasionally	□ Everyday	Prayer or meditation?	□ Yes	□ No
Coffee use:	□ Never	□ Occasionally	□ Everyday	Job Pressure/stress?	□ Yes	□ No
Exercising:	□ Never	□ Occasionally	□ Everyday	Financial stress?	□ Yes	□ No
Pain Relievers:	□ Never	□ Occasionally	□ Everyday	Vaccinated?	□ Yes	□ No
Soft Drinks:	□ Never	□ Occasionally	□ Everyday	Recreational Drugs	□ Yes	□ No
Water Intake:	□ Never	□ Occasionally	□ Everyday			

Operations (please list ALL that apply)

□ Appendix removal □ Bypass Surgery □ Cosmetic Surgery □ Eye Surgery □ Hysterectomy □ Vasectomy □ C-section

□ Pacemaker □ Tonsillectomy □ Thyroid Surgery □ Cancer: _____

□ Gallbladder □ Hip RT or LT □ Shoulder RT or LT □ Knee RT or LT □ Foot/ankle RT or LT □ Arm/wrist RT or LT

□ Spine: _____

□ Other:_____

Injuries

□ Sports Injury: what type & when _____

□ Spinal Injuries: what type & when _____

□ Slip and Fall: how & when_____

□ Past automobile accidents: when & describe_____

_____

Patient's Signature _____ **Date** _____/_____/_____

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Patient Name:_____**Patient #:**_____**Today's Date:** _____/_____/_____**Doctor's Initials:**_____

Do you currently take vitamins/ minerals? □ **No** □ **Yes, If so what types:** _____

_____

Please list current medications and dosage

□ **NO Medication at this time**

Name of medication	Dosage	How many times a day	In Morning	At Night

Please Describe the PRIMARY reason for consulting our office

PRIMARY Symptom: □ Left Side □ Right Side □ Both

PRIMARY Symptom onset began on what date:

Pain Rating (1-10, with 10 being worst pain): □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Please check any activities that are more difficult due to the above symptom:

□ Sitting □ Walking □ Standing □ Lifting □ Lying down □ Bending

□ Dressing □ Reaching □ Concentrating □ Sleeping □ Twisting □ Driving

□ Exercise □ Sports □ Looking down □ Sneezing □ Coughing □ House work

□ Work activities (please list): _____

□ Other: _____

Pain Frequency:

□ Constant

□ Intermittent

□ Occasional

Pain Pattern:

Morning: □ Better □ Worse □ Same

Afternoon: □ Better □ Worse □ Same

Evening: □ Better □ Worse □ Same

All Day □

Pain Quality:

□ Aching □ Burning

□ Cramping □ Sharp

□ Shooting □ Dull

□ Numbness □ Tingling

□ Stiffness □ Diffuse

□ Tight □ Radiating

Pain Relieved By:

□ Exercise □ Walking □ Heat

□ Ibuprofen □ Sitting □ Ice

□ Standing □ Stretching □ Medication

□ Lying Down □ No Movement

□ No Relief

Pain aggravated by:

□ Bending □ Lifting □ Lying down □ Increased activity

□ Twisting □ Reaching □ Getting up/down □ House work

□ Walking □ Coughing □ Looking down □ Exercising

□ Standing □ Sneezing □ Work Duties □ Driving □ Sitting

□ Turning □ Other:_____

Pain Cause:

□ A Fall

□ Work Injury

□ Auto Accident

□ Illness

□ Sport Injury

□ Gradual Onset

□ Unknown

□ Other:_____

_____

_____

_____

What has been done to treat this symptom:

□ Acupuncture

□ Surgery

□ Massage

□ OTC Medication

□ Prescription Medication

□ Ice

□ Heat

□ Other:_____

_____

_____

□ No other treatment

Pain Radiates Into

□ Left arm □ Right arm

□ Left hand □ Right hand

□ Left leg □ Right leg

□ Left foot □ Right foot

□ Left hip □ Right hip

□ Left shoulder

□ Right shoulder

□ Other _____

_____

_____

_____

□ No Radiating Pain

Patient's Signature _____ **Date** _____/_____/_____

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Patient Name:_____**Patient #:**_____**Today's Date:** _____/_____/_____**Doctor's Initials:**_____

Please Describe the secondary reason for consulting our office

SECONDARY Symptom: □ Left Side □ Right Side □ Both

SECONDARY Symptom onset began on what date:

Pain Rating (1-10, with 10 being worst pain): □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Please check any activities that are more difficult due to the above symptom:

□ Sitting □ Walking □ Standing □ Lifting □ Lying down □ Bending

□ Dressing □ Reaching □ Concentrating □ Sleeping □ Twisting □ Driving

□ Exercise □ Sports □ Looking down □ Sneezing □ Coughing □ House work

□ Work activities (please list): _____ □ Other: _____

Pain Frequency:

□ Constant

□ Intermittent

□ Occasional

Pain Pattern:

Morning: □ Better □ Worse □ Same

Afternoon: □ Better □ Worse □ Same

Evening: □ Better □ Worse □ Same

All Day □

Pain Quality:

□ Aching □ Burning

□ Cramping □ Sharp

□ Shooting □ Dull

□ Numbness □ Tingling

□ Stiffness □ Diffuse

□ Tight □ Radiating

Pain Relieved By:

□ Exercise □ Walking □ Heat

□ Ibuprofen □ Sitting □ Ice

□ Standing □ Stretching □ Medication

□ Lying Down □ No Movement

□ No Relief

Pain Cause:

□ A Fall

□ Work Injury

□ Auto Accident

□ Illness

□ Sport Injury

□ Gradual Onset

□ Unknown

□ Other:_____

_____

_____

_____

What has been done to treat this symptom:

□ Acupuncture

□ Surgery

□ Massage

□ OTC Medication

□ Prescription Medication

□ Ice

□ Heat

□ Other:_____

_____

_____

□ No other treatment

Pain Radiates Into:

□ Left arm □ Right arm

□ Left hand □ Right hand

□ Left leg □ Right leg

□ Left foot □ Right foot

□ Left hip □ Right hip

□ Left shoulder

□ Right shoulder

□ Other _____

_____

_____

_____

□ No Radiating Pain

Pain aggravated by:

□ Bending □ Lifting □ Lying down □ Increased activity

□ Twisting □ Reaching □ Getting up/down □ House work

□ Walking □ Coughing □ Looking down □ Exercising

□ Standing □ Sneezing □ Work Duties □ Driving

□ Sitting □ Turning □ Other:_____

Please check any health condition or symptom that YOU have HAD or currently HAVE

Condition	Have	Had		Have	Had		Have	Had		Have	Had
Neck Pain/Stiffness			Sciatica Right Leg			Numbness/Tingling Rt Arm			Scoliosis		
Mid-Back Pain/Stiffness			Sciatica Left Leg			Numbness/Tingling Lt Arm			Fibromyalgia		
Low Back Pain/Stiffness			Left Hip Pain			Numbness/Tingling Rt Leg			Irritability		
Headaches			Right Hip Pain			Numbness/Tingling Lt Leg			Extreme Fatigue		
Migraine Headaches			Eye Light Sensitive			Left Foot/Ankle Pain			Depression		
Concussion			Skin Changes			Right Foot/Ankle Pain			Fainting		
Eye pain/Strain			Ears buzzing/Ringing			Left Shoulder Pain			Nervousness		
Eye Light Sensitivity			Chronic Ear Infections			Right Shoulder Pain			Bad Menstrual Cramps		
Nausea, Vomiting			Bed Wetting			Chest Pain			Poor Circulation		
Vertigo			Constipation			Palpitation			Bone Fracture		
Sinus Trouble			Diarrhea			Heart Trouble			Dislocated Joints		
TMJ Pain			Loss of Bowel Control			Shortness of Breath			Weight Gain		
Convulsions			Loss of Taste or Smell			Angina			Weight Loss		
Ulcers			Loss of Memory			Herniated Disc			Osteoporosis		
Asthma			Insomnia			Bulging Disc			Rheumatoid Arthritis		

Please Indicate which condition exist or have existed by checking the boxes below

Family History	Self	Mother	Father	Sister	Brother	child	Family History	Self	Mother	Father	Sister	Brother	Child
Cancer, Type:	□	□	□	□	□	□	Crohn's Disease	□	□	□	□	□	□
Cancer, Type:	□	□	□	□	□	□	Irritable Bowel Disease	□	□	□	□	□	□
Cancer, Type :	□	□	□	□	□	□	Gastrointestinal Disorder	□	□	□	□	□	□
Allergies	□	□	□	□	□	□	Ulcerative Colitis	□	□	□	□	□	□
Alcoholism	□	□	□	□	□	□	Stroke	□	□	□	□	□	□
AIDS	□	□	□	□	□	□	Malaria	□	□	□	□	□	□
Arteriosclerosis	□	□	□	□	□	□	Rheumatic Fever	□	□	□	□	□	□
Gout	□	□	□	□	□	□	Polio	□	□	□	□	□	□
Glaucoma	□	□	□	□	□	□	Clotting Disorder	□	□	□	□	□	□
Tuberculosis	□	□	□	□	□	□	Autoimmune Disorder	□	□	□	□	□	□
Measles	□	□	□	□	□	□	Parkinson's Disease	□	□	□	□	□	□
Multiple Sclerosis	□	□	□	□	□	□	Hepatitis	□	□	□	□	□	□
Scarlet Fever	□	□	□	□	□	□	HIV Positive	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□	Epilepsy	□	□	□	□	□	□
Lung Disease/COPD	□	□	□	□	□	□	Alzheimer's	□	□	□	□	□	□
High Cholesterol	□	□	□	□	□	□	Diabetes	□	□	□	□	□	□
Heart Disease/Heart Attack	□	□	□	□	□	□	Gestational Diabetes	□	□	□	□	□	□
Thyroid Disease	□	□	□	□	□	□	Kidney Disorder	□	□	□	□	□	□

Primary Doctor: _____ **Phone # :**_____
Address: _____
City:_____ **Sate:** _____ **Zip:**_____

Primary Insurance Company: _____
Name of Insured:_____ **Date Of Birth:**_____
Relationship to insured:_____
Policy # :_____
Phone # :_____

Doctor's Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient's Signature _____ Date _____/_____/_____