Confidential Patient Information and Health History

(Please fill out completely)

Full Legal Name_____ **Name you prefer**_____

Mailing Address_____City_____State_____ Zip _____

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

Home Email _____ Work Email_____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided

Age_____ Date of Birth _____ Sex _____ Soc.Sec.No._____ Years of Education____

Circle one: Married Single Widowed Divorced Separated

Employer_____Address_____

Name of Spouse_____ Number of Children_____

Spouse's Address_____Telephone_____

Emergency Contact_____Telephone_____

Your Occupation_____

If this is your first visit, how were you referred to our office? _____

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Reason For This Visit

What symptoms have caused you to seek care in this office (if back pain, please be specific)? _____

_____

Date symptoms first began _____How did your symptoms first begin? _____

_____

Secondary Symptoms of concern:_____

Pain is: Constant ❒ Intermittent (off/on) ❒ Is your condition getting? Worse ❒ Better ❒ Same ❒

What activities aggravate your symptoms? _____

What activities lessen your symptoms? _____

Is it worse during certain times of the day? _____ List remedies tried _____

Have you recently missed work due to your condition? Yes❒ No❒

Is the condition interfering with job performance? Yes❒ No❒ Sleep? Yes❒ No❒ Routine? Yes❒ No❒

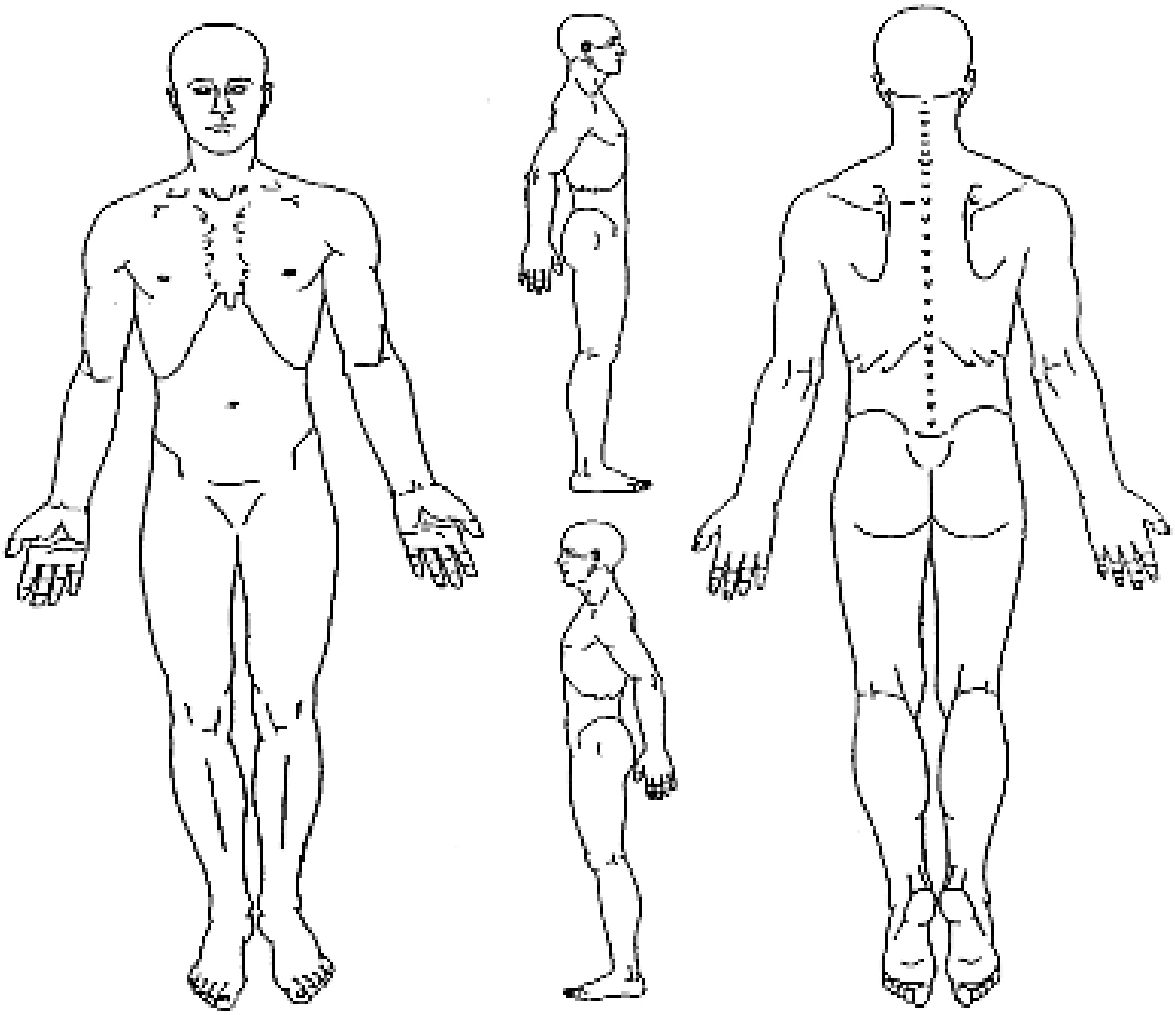
Other doctors seen for this condition _____

(please turn this page over)

Pain Diagram

Instructions:
1) Mark the areas where you feel abnormal sensations using the letter codes listed below.
2) Rate each area of pain intensity on a 0-10 scale (0= no pain; 10= worst possible pain).
3) Draw a large arrow to the area that you consider your PRIMARY reason for seeking treatment.

Aching	**Numbness**	**Pins/Needles**	**Burning**	**Sharp/Stabbing**	**Stiff/tight**
AAAAA	NNNNN	PPPPP	BBBBB	SSSSSS	TTTTTT



Name: _____ Date: _____

Medical History

Have you ever had or do now have any of the following?

Use the letter **C if you have a current condition, OR the letter **P** if you have previously had the condition.
C = Currently P = Previously

Cardiovascular: __Poor Circulation __High blood pressure __Aortic aneurysm __Stroke __Heart disease __Vascular disease __Heart attack __Chest pain __High cholesterol __Pacemaker __Jaw pain __Irregular heartbeat __Swelling of legs

Genitourinary: __Kidney disease __Lower side pain __Burning urination __Frequent urination __Blood in urine __Kidney stone __prostate problems (male)

Hematologic/lymphatic: __Hepatitis __Anemia __Blood clots __Easy bruising __Easy bleeding

Respiratory: __Asthma __ Tuberculosis (TB) __Short of breath __Emphysema __Colds/flu __Cough/wheeze __Pneumonia

EENT: __Glaucoma __Double vision __Blurry vision __Dizzy __Hearing loss __Loss of smell __Loss of taste __Sinus infection __Nosebleed __Sore throat __Difficulty swallowing __Bleeding gums

Integumentary: __Skin ulcers __Skin disease __Eczema __Psoriasis __Rashes

Allergic/immunologic: __Hives __Immune disorder __HIV/AIDS __Allergy shots __Cortisone use __Cancer (any)

Gastrointestinal: __Gallbladder problems __Bowel problems __Constipation __Liver problems __Ullcers __Diarrhea __Nausea/vomiting __Bloody stools __Poor appetite __Polyps

Musculoskeletal: __Gout __Arthritis __Joint stiffness __Muscle weakness __Osteoporosis __Broken bones __Joints replaced

Neurological: __Seizures/convulsions __Head injury __Headaches __Pinched nerves __Carpal tunnel __Parkinson's __Alzheimer's __Vertigo __Memory loss __Fainting __Numbness or Pins/ needles

Endocrine: __Thyroid disease __Diabetes __Hair loss __Menopausal __Menstrual problems

Psych: __Depression __Anxiety __Bipolar __Schizophrenia __Unusual stress __Unusual anger

Constitutional: __Weight loss/weight gain __Energy level decreased/fatigue __Difficulty sleeping

Have ever had: Surgery: Yes❒ No❒ Fractures: Yes❒ No❒ Car Accident: Yes❒ No❒ Falls: Yes❒ No❒ On-Job Injury: Yes❒ No❒ Please explain any "Yes" answers (include dates, if known):

_____
_____
_____

Previous hospitalization: (Please date & describe) _____
_____

Who is your **Primary Doctor/Provider**? _____

Facility name _____ Date of last physical exam _____

(Please turn this page over)

Name: _____ Date: _____

List current **prescription** medications. If none are taken then check here: ❒

_____

_____

Are you allergic to any medications? ❒No/unknown ❒Yes (please list) _____

_____

Have you been seen or treated for **any** health condition by a healthcare provider in the last year? Yes❒ No❒

If yes, explain_____

Have you ever had chiropractic care? ❒Yes ❒No

If yes, who/where?_____
What were you seen for? ❒My present complaint(s) ❒Other _____
How long ago were you last seen? _____

*__Female Only__: Are you possibly pregnant? ❒Yes ❒No Date of last menstrual period _____

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Family History

Has a grandparent, parent, brother or sister ever had:

Heart disease	Yes❒	No❒	Cancer	Yes❒	No❒
Diabetes	Yes❒	No❒	Arthritis	Yes❒	No❒
Back problems	Yes❒	No❒	Stroke	Yes❒	No❒

Other _____

Social and Occupational History

1. Please check the activities that your ***job or daily routine*** typically requires:

❒ Sitting at a desk	❒ Standing in place	❒ Walking
❒ Lifting and carrying	❒ Bending, twisting	❒ Crouching or kneeling
❒ Repetitive use of hands	❒ Other_____	

2. ***Smoking and tobacco***
❒Never a smoker ❒Former smoker ❒Current every day smoker ❒Current occasional smoker

3. ***Alcohol use per week***
❒ None ❒1 drink/week ❒2-7 drinks/week ❒8-14 drinks/week ❒15+ drinks/week

4. ***Exercise*** (for this question, exercise means at least 30 minutes of continuous activity)
❒ Not exercising ❒ 1 day/month ❒ 1 day/week ❒ 2 days/week ❒ 3-5 days/week

5. **Dietary Intake of Fruits and Vegetables**
❒ No servings/week ❒ 1-4 servings/week ❒ 1 serving/day ❒ 2 servings/day ❒ 3+ servings/day

Name: _____ Date: _____