

CONFIDENTIAL PATIENT HEALTH HISTORY

Today's Date: _____

Patient #: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____ - ____ - ____ Age: ____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Cell Phone: _____

Marital Status: Single Married Spouse's Name: _____

Work Phone: _____ Number of Children & Ages: _____

Employer: _____ Occupation: _____

Name & Number of Emergency Contact: _____ Relationship: _____

Whom may we thank for referring you to this office? _____

Are you pregnant? N Y Due Date: _____

If **job related**, have you reported this accident to your employer? N Y, _____ Date of injury

If related to a **car accident**, have you reported this injury to the insurance? N Y, _____ Date occurred

FINANCIAL INFORMATION – Please allow our staff to photocopy your insurance card.

Insurance Self-Pay (cash) Personal/Auto Other (please explain) _____

Primary Insurance

Name: _____

Relation to Insured: Self/Spouse/Parent/Child/Other

Other than self:

Insured's Name: _____

Date of Birth: _____ M F

Social Security #: _____

Secondary Insurance

Name: _____

Relation to Insured: Self/Spouse/Parent/Child/Other

Other than self:

Insured's Name: _____

Date of Birth: _____ M F

Social Security #: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to our office today:

First: _____ How Long? _____ Second: _____ How Long? _____

Third: _____ How Long? _____ Fourth: _____ How Long? _____

On a scale of **1** to **10** with 10 being the worst and **zero** being no pain, rate the above complaints by **circling**:

First complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Describe how your primary complaint began. What caused it or what were you doing when you noticed the pain?

Is the complaint/pain? Dull/ Achy/ Burning/ Sharp/ Numb/ Stiff & Sore/ Stabbing/ Other _____

Does the complaint radiate/shoot to any areas of your body? No / Yes *If Yes, circle where below:*

Head – Base of Skull / Forehead / Temples R / L / Both Leg – Hip / Thigh-Knee/ Foot-Toes R / L / Both

Arm – Shoulder / Elbow/ Hands-fingers R / L / Both Other Area: _____

What makes your symptoms feel better? Ice / Heat / Rest / Movement / Stretching / Medication / Other: _____

What makes your symptoms feel worse? Sit / Stand / Lying / Walking / Overuse / Sleep / Other: _____

How frequent are the symptoms? Constant / Comes & Goes -- on & off during the day / on & off during the week

Have you received any prior care for this condition? MD / PT / Massage / Urgent Care / Acupuncture / Other:

Have you seen a Chiropractor before? N Y If yes, who & when? _____

What were the results? Favorable Unfavorable → please explain:

Have you had any other injury(s) to your spine, minor or major? List even if it was over 20 years ago:
car accidents / slips & falls / sports injuries / military / police / fire background / hospitalizations / etc.

How does this condition affect your daily activities? *Can't workout or pick up kids or concentrate at work or sit through a movie...*

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following conditions: None

Tumors Cancer Heart Attack Diabetes Autoimmune Rheumatoid Arthritis Fractures

Osteoarthritis Cerebral-Vascular Any other medically diagnosed conditions? _____

*Indicate if you have ever been diagnosed with any of the following: **P** for in the **Past**, **C** for **Currently***
(Circle the one that applies - ie: Diarrhea/Constipation)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Recent Weight Change | <input type="checkbox"/> Sinus/Allergies | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Diarrhea / Constipation |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Ringing/Buzzing in Ears | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blood in Stool / Urine |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pain behind Eyes | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Nausea / Vomiting |
| <input type="checkbox"/> Sciatica L/R | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Heart Palp/Murmur | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Hip Pain L/R | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Cold Sweats/Hot Flash | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Loss of Taste/Smell | <input type="checkbox"/> Asthma / Wheezing | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Dizziness/ light-headed | <input type="checkbox"/> Faint/Loss of Balance | <input type="checkbox"/> Upper Resp. Infection | <input type="checkbox"/> Cramping/Irregular Periods |
| <input type="checkbox"/> Pain/Numb Arms-Legs | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Heart Burn/Indigestion | <input type="checkbox"/> Difficulty Getting Pregnant |
| <input type="checkbox"/> Tingling/Weak Arm-Leg | <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcers/Acid Reflux | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Weak muscles or Joints | <input type="checkbox"/> Stroke | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Nervousness/Anxiety |
| <input type="checkbox"/> Stiff / Swollen Joints | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Memory Loss/ Confusion | <input type="checkbox"/> Mood Swings/Irritable |

List any surgical operations and year they were performed: (type / year / right or left)

List any broken bones / fractures or dislocations you have had: (right or left / year)

List any medications you are taking: Did you bring a list? May we make a copy? None

List any vitamins or supplements you are taking: Did you bring a list? May we make a copy? None

FAMILY HISTORY

ie: Relationship: Maternal Grandmother

- Heart Disease Relationship: _____
- Stroke Relationship: _____
- Cancer Relationship: _____
- Autoimmune Relationship: _____

Type of Cancer or Autoimmune: _____

Any other family history that might be relevant? _____

SOCIAL HISTORY

- Do you smoke? No Yes _____ packs/day
- Do you drink coffee? No Yes _____ cups/day
- Do you wear Heel Lifts: No Yes
- Do you drink alcohol? No Yes _____ drinks/day
- Do you exercise regularly? No Yes
- Do you do recreational drugs? No Yes

Is there anything else you would like the doctor to know? _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services. I clearly understand and agree that all services rendered are ultimately my responsible for payment.

Patient or Guardian Signature

_____-_____-_____
Date Completed

Doctor's Signature

_____-_____-_____
Date Form Reviewed