PATIENT HISTORY

Patient #______________

Name______________________________ Birth Date______________ Age________
Address:______________________ City:______________ State:__________ Zip:__________
Phone: (c)____________ (h)____________ (w)____________ Email:______________
Please Check: ☐Married ☐ Single ☐ Male ☐ Female ☐ Right-handed ☐ Left-Handed

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List your reasons for seeking chiropractic care in order of importance to you:

1.______________________ 4.______________________
2.______________________ 5.______________________
3.______________________ 6.______________________

When & How did this first start?______________________________

Does anything make it better or worse? (movement, position, ice, heat, etc.) Explain:______________________

Describe your symptom(s): ☐ Constant ☐ Comes & Goes ☐ Getting better ☐ Getting Worse ☐ Staying the Same
Has this ever happened before: ☐ Yes, when?______________________ ☐ No
Does the pain move or radiate? ☐ Yes, where?______________________ ☐ No

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Describe any other health problems you have and how long you have had them:______________________

Are you under the care of any other doctor? ☐Yes ☐ No If yes, the condition being treated for:______________

List any current medications (prescription & OTC):______________________

List any past surgeries & dates:______________________
List any past accidents & dates:______________________
List any x-rays you've had in the past 2 years:______________________

Personal & Family History:

Your occupation:______________________ Your work duties:______________
Spouse/significant other's health status:______________________
Children's ages & health status:______________________

Chiropractic History:

Have you ever had Chiropractic Care before? ☐Yes ☐ No If yes, Doctor's Name:______________
Date of last chiropractic visit:______________ Reason for care:______________
Date of last chiropractic x-rays:______________ How long were you under care?______________
Are other family members under chiropractic care? ☐Yes ☐ No If yes, who?______________

Wellness Commitment:

At this Chiropractic office we are dedicated to achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness.

10%.........20%.........30%.........40%.........50%.........60%.........70%.........80%.........90%..........100%

Where did you hear about our clinic, or who referred you?______________________

FEMALES: Please check one ☑ - Is there a possibility of you being pregnant? ☐Yes ☐ No

Please Fill in Below: If you have had the following, or if you suffer from the following, Please Check ✓

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occassionally
Headache	☐	☐
Migraines	☐	☐
Neck Pain	☐	☐
Shoulder Pain	☐	☐
Arm/Hand Pain	☐	☐
Mid-Back Pain	☐	☐
Low Back Pain	☐	☐
Hip Pain	☐	☐
Leg/Foot Pain	☐	☐
Disc Problems	☐	☐
Arthritis	☐	☐
Other joint pain	☐	☐
Numbness	☐	☐
Joint Swelling	☐	☐
Dizziness	☐	☐
Nausea	☐	☐
Digestive problems	☐	☐
Weakness	☐	☐
Fatigue	☐	☐
Nervousness	☐	☐
Insomnia	☐	☐
Heart Problems	☐	☐
Frequent colds	☐	☐
Nose Bleeds	☐	☐
Ringing in Ears	☐	☐
Earaches	☐	☐
Hearing Loss	☐	☐
Cough	☐	☐
Chest Pains	☐	☐
Female Problems	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Osteoporosis	☐	☐
Diabetes	☐	☐
Hypoglycemia	☐	☐
Urinary Problems	☐	☐
Skin Conditions	☐	☐
Other:	☐	☐

Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

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In an effort to help meet your health goals, Please fill in the following:

Strengths: strong habits are key to health. It helps us take care of you if we have an idea of how you take care of your body. Add any others that are relevant & **circle your top 3.**	
Stretch 3-5 times a week	Exercise 3-5 times a week
Drink ½ my body wt in ounces of water	Take supplements for health
Have a positive attitude	Sleep 6-8 hours a night
Drink or eat something green every day	Get maintenance chiropractic 2-4 times/yr
Do activities to minimize stress regularly	Non-smoker
Other:	

Goals: We want to make sure you get lasting relief and enjoy maximum functional improvement. Add any others that are relevant & **circle your top 3.**	
Sleep through the night	Exercise again
Continue working/get back to work	Avoid future flare ups
Play with kids/grandkids normally	Get off pain medications
Be ready for an upcoming event	Have a better attitude
Have some moments of relief	Sit/stand comfortably for an extended period of time
Other:	

Your Signature Below Please:

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Date:___________________________________

Thank you for being complete and thorough!