

## PATIENT HISTORY

**Name:** \_\_\_\_\_ **Preferred Name:** \_\_\_\_\_  
**Street:** \_\_\_\_\_ **Apt:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
**Email Address:** \_\_\_\_\_ **Relationship Status:** S M W D Partnered  
**Date of Birth:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
**Sex assigned at birth:**  Male  Female  Declined to State  
**Preferred Pronouns:**  He/Him  She/Her  They/Them

List any **Non Medication Allergies:**

Animal  Bees  Chocolate  Dairy  Dust  Eggs  Latex  Molds  Peanut/Tree Nut  Ragweed/Pollen  Rubber  
 Seasonal Allergies  Scents/Perfumes  Shell fish  Soaps  Wheat  X-Ray Dye  Other: \_\_\_\_\_

List any **Surgeries, and write in the date:**

Ankle \_\_\_\_\_  Back \_\_\_\_\_  Elbow \_\_\_\_\_  Foot \_\_\_\_\_  Hip \_\_\_\_\_  Knee \_\_\_\_\_  Neck \_\_\_\_\_  
 Neurological \_\_\_\_\_  Shoulder \_\_\_\_\_  Wrist \_\_\_\_\_  Other: \_\_\_\_\_

**Past Medical History**

Please put a check mark next to all past or current complaints:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> ADD/ADHD         | <input type="checkbox"/> Fibromyalgia               | <input type="checkbox"/> Low back Pain         | <input type="checkbox"/> Scoliosis        |
| <input type="checkbox"/> Ankle Pain       | <input type="checkbox"/> Foot Pain                  | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Arm Pain         | <input type="checkbox"/> Hand Pain                  | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Shingles         |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Lupus                 | <input type="checkbox"/> Sprain/Strain    |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Menstrual Problems    | <input type="checkbox"/> Spinal Condition |
| <input type="checkbox"/> Broken Bones     | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Mid-Back Pain         | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Hip Pain                   | <input type="checkbox"/> Multiple Sclerosis    | <input type="checkbox"/> Tumor            |
| <input type="checkbox"/> Concussion       | <input type="checkbox"/> HIV                        | <input type="checkbox"/> Neck Pain             |   |
| <input type="checkbox"/> Type I Diabetes  | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Neurological Problems |   |
| <input type="checkbox"/> Type II Diabetes | <input type="checkbox"/> Jaw Pain                   | <input type="checkbox"/> Pacemaker             |   |
| <input type="checkbox"/> Eczema           | <input type="checkbox"/> Joint Stiffness            | <input type="checkbox"/> Parkinson's           |   |
| <input type="checkbox"/> Elbow Pain       | <input type="checkbox"/> Knee Pain                  | <input type="checkbox"/> Polio                 |   |
| <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Leg Pain                   | <input type="checkbox"/> Prostate Problems     |   |

**Primary Care Physician:** \_\_\_\_\_

**Facility:** \_\_\_\_\_ **City/Town:** \_\_\_\_\_

**Date of last physical examination:** \_\_\_\_\_

**If you have any other medical records you would like us to have, i.e., x-rays, blood work, office notes, please inform the front desk staff. Please note that you will need to request records if they are from out of state.**

List any **medications and what condition this medication is treating** that you are currently taking: (Attach a list if necessary.)

**Medications:**

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**Nutritional Supplements:**

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**Medication Allergies:**

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**Family History** (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother, Paternal Grandfather (**PG**), Paternal Grandmother (**PM**), Maternal Grandfather (**MF**), Maternal Grandmother (**GM**).

\_\_\_\_ Arthritis \_\_\_\_ Cancer \_\_\_\_ Diabetes \_\_\_\_ Heart Disease \_\_\_\_ Multiple Sclerosis \_\_\_\_ Scoliosis \_\_\_\_ Stroke \_\_\_\_ Other

**Social History**

**Alcohol:**  Never  Social Consumption  Beer  Wine  Liquor \_\_\_\_ (#) of \_\_\_\_ oz. per  Day  Week  Month

**Tobacco:**  Deny tobacco use  Live with a smoker  Quit Smoking \_\_\_\_ year  Smoke/Chew; # \_\_\_\_ / day/week/month

**Caffeine:**  No  Yes - how many per day? \_\_\_\_\_ **Use recreational drugs?**  No  Yes  Quit

**Education:** Please list the highest level completed: \_\_\_\_\_

**Diet:** Please list any special diet of which we should be aware: \_\_\_\_\_

**Exercise:**  No  Yes (what forms and how often): \_\_\_\_\_

**Sleep:** How many hours of consecutive sleep do you get on weekdays? \_\_\_\_\_ weekends? \_\_\_\_\_

**Accidents:** Have you had any auto or other accidents?  No  Yes Describe: \_\_\_\_\_

**Have you had any concussions?**  No  Yes Describe: \_\_\_\_\_

**Employment:**

**Occupation:** \_\_\_\_\_ **Work** \_\_\_\_\_ hours per day

**Job Classification:**  Sedentary (lift less than 5 lbs)  Light (6-20 lbs)  Moderate (21-49 lbs)  Heavy (over 50 lbs)

What **percentage** of time during the day (at home or at your job away from home) do you spend:

Lifting \_\_\_\_ Sitting \_\_\_\_ Bending \_\_\_\_ Working at a computer \_\_\_\_ Phone \_\_\_\_

**Are there any other problems you want to discuss with the chiropractor?**

- ADHD / ASD / Behavior issues  Carpal Tunnel  Exercise counseling  Fatigue  Foot Pain/ Orthotics  Headaches  
 Knee Pain  Shoulder pain  Sleep issues  Stress  Vitamins/supplements  Weight loss  Wellness care

Have you ever had chiropractic care?  No  Yes

When? \_\_\_\_\_ Why? \_\_\_\_\_ Where? \_\_\_\_\_ Date of last adjustment \_\_\_\_\_

Were X-rays taken?  No  Yes If so, when? \_\_\_\_\_

1. What is your **MAJOR complaint**? \_\_\_\_\_ Date problem began? \_\_\_\_\_

2. How did this problem **begin** (falling, lifting, etc.)? \_\_\_\_\_

3. How is your condition **changing**?  Getting Better  Getting Worse  Not Changing

4. Have you had this condition in the **past**?  Yes  No

5. Please circle the number below to indicate **level of problem** (0= no symptoms and 10 = excruciating symptoms)

0 1 2 3 4 5 6 7 8 9 10

6. Please rate the **intensity** of the pain:  Minimum  Mild  Moderate  Severe  Unbearable  None

7. Describe the **nature** of your symptoms:

Burning  Dull Ache  Numb  Radiating Pain  Sharp  Shooting  Tightness  Tingling  Throbbing

8. What makes your pain **better** (ice, heat, massage, etc.)? \_\_\_\_\_

9. What are your **expectations** for care?  Become pain free  Explanation of my condition

Learn how to care for this on my own  Reduce symptoms  Resume normal activity

10. How **often** do you experience your symptoms?  Constantly (76-100% of the day)  Frequently (51-75% of the day)

Occasionally (26-50% of the day)  Intermittently (0-25% of the day)

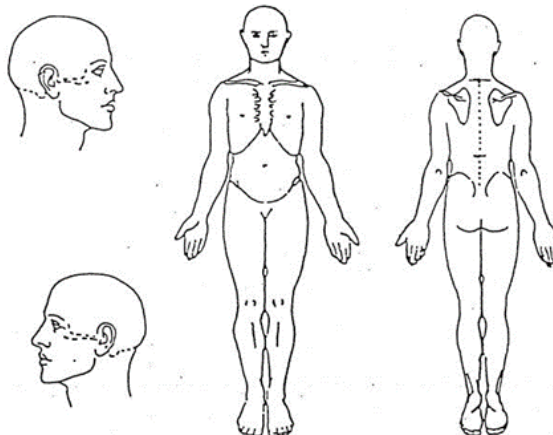
11. What activities **aggravate** your condition (working, exercise, etc.)? \_\_\_\_\_

12. What treatment have you **already received** for your condition?  Medications  Surgery  Injections  Physical Therapy

Chiropractic Services  Massage Therapy  None  Other \_\_\_\_\_

Name of other doctor (s) who have treated you for your condition \_\_\_\_\_

Mark the area (s) on your body where you feel the described sensation.



Additional Comments:



**Review of Systems - Please fill out each section even if section is "I do not have any..."**

**Constitutional:**  I do not have constitutional issues

- Chills  Daytime Somnolence (drowsiness)  Fatigue  Fever  Night Sweats  Weight Gain  Weight Loss

**Eyes/Vision:**  I do not have eye/vision issues

- Blindness  Blurred Vision  Cataracts  Change in Vision  Double Vision  Eye Pain  Visual field defect  
 Glaucoma  Itching (around the eyes)  Photophobia  Tearing  Wear Glasses and/or Contact Lenses

**Ears, Nose and Throat:**  I do not have ears, nose and throat issues

- Bleeding  Dental Implants  Dentures  Difficulty Swallowing  Discharge  Dizziness  Ear Drainage  
 Ear Infection(s)  Ear Pain  Fainting  Headaches  Head Injury (history of)  Hearing Loss  Hoarseness  
 Loss of Smell  Nasal Congestion  Nose Bleeds (frequent)  Post Nasal Drip  Rhinorrhea (runny nose)  
 Sinus Infection  Snoring  Sore Throats (frequent)  Teeth Grinding  Tinnitus  TMJ (jaw) Problems

**Respiration:**  I do not have respiratory issues

- Asthma  Cough  Coughing up Blood  COVID/Long Haulers Syndrome  Shortness of Breath  
 Coughing Phlegm  Wheezing

**Cardiovascular :**  I do not have cardiovascular issues

- Angina (chest pain or discomfort)  Chest Pain  Claudication (leg pain or achiness)  Heart Murmur  Heart Problems  
 Orthopnea (difficulty breathing while laying down)  Palpitations (irregular or forceful beating of the heart)  
 Paroxysmal Nocturnal Dyspnea (waking up at night with shortness of breath)  
 Shortness of Breath with Exertion or Exercise  Swelling of Legs  Ulcers  Varicose Veins

**Gastrointestinal :**  I do not have gastrointestinal issues

- Abdominal Pain  Belching  Black, Tarry Stools  Constipation  Diarrhea  
 Difficulty Swallowing  Heartburn  Hemorrhoids  Indigestion  Jaundice (yellowing of the skin)  Nausea  
 Rectal Bleeding  Abnormal Stool Color  Abnormal Stool Consistency  Vomiting  Ulcers  Vomiting Blood

**Female :**  I do not have female issues

- Birth Control Therapy  Breast Lumps/Pain  Burning Urination  Cramps  Frequent Urination  Hormone Therapy  
 Irregular Menstruation  Pain with Sex  Urination with Laughing  Urine Retention  Vaginal Bleeding or Discharge

**Male :**  I do not have male issues

- Burning Urination  Erectile Dysfunction  Frequent Urination  Hesitancy/Dribbling  Pain with Sex  Prostate Problems  Urine Retention

**Skin :**  I do not have skin issues

- Changes in Nail Texture  Changes in Skin Color  Hair Growth  Hair Loss  Hives  Itching  
 Paresthesia (numbness, prickling, tingling)  Rash  History of Skin Disorders  Skin Lesion/Ulcers  Tremors

**Nervous System :**  I do not have nervous system issues

- Dizziness  Facial Weakness  Headaches  Limb Weakness  Loss of Consciousness  Loss of Memory  Numbness  
 Seizures  Sleep Disturbance  Slurred Speech  Stress  Strokes  Tremors  Unsteadiness of Gait

**Psychological :**  I do not have psychological issues

- Anhedonia (inability to experience joy or enjoy life)  Anxiety  Appetite Changes  Behavioral Changes  
 Bipolar Disorder  Confusion  Convulsions  Depression  Insomnia  Memory Loss  Mood Changes

**Allergy :**  I do not have allergy issues

- Anaphylaxis (history of)  Food Intolerance  Itching  Nasal Congestion  Sneezing

**Hematology (Blood) :**  I do not have hematology issues

- Anemia  Bleeding  Blood Clotting  Blood Transfusion (s)  Bruises Easily  Fatigue  Lymph Node Swelling

**Condition's Effect on Daily Life**

	No Effect	Mild (painful, can do)	Moderate (painful/limited)	Severe (unable to do)
Bending				
Caring for Family				
Carrying groceries				
Change position (sit/stand)				
Climbing Stairs				
Daily Pet Care				
Driving				
Extended Computer Use				
Eating				
Household Chores				
Kneeling				
Lifting				
Reading				
Self-Care-Bath, Dressing etc				
Sexual Activities				
Sleep				
Sitting Still				
Standing Still				
Walking				
Yard Work				
Other _____				

**Ob/Gyn:**  I do not have OB/GYN issues

I  have never been pregnant  have been pregnant in the past  am currently pregnant \_\_\_\_\_ Due Date  
 \_\_\_\_\_ Number of pregnancies \_\_\_\_\_ # of complicated pregnancies \_\_\_\_\_ # of uncomplicated pregnancies  
 \_\_\_\_\_ # of miscarriages \_\_\_\_\_ # of terminated pregnancies \_\_\_\_\_ # of epidural injection  
 \_\_\_\_\_ # of C-sections \_\_\_\_\_ # of vaginal deliveries

**Menstrual History** Age of onset \_\_\_\_\_ My menses is  Regular  Irregular  
 I am currently in  Pre-menopause  Menopause Date of last menses \_\_\_\_/\_\_\_\_/\_\_\_\_

Would you like a copy of your initial electronic medical record from our office for yourself ? Yes No

Or sent to another provider? \_\_\_\_\_

**MY PRIVACY**

I have been offered/received a copy of the **Notice of Privacy Practices**. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; obtain payment from third-party payers; conduct normal healthcare operations such as quality assessments and accreditation.

X \_\_\_\_\_  
 Signature of patient or person acting on patient's behalf Date