

Date \_\_\_\_\_

### Patient Health History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: MF  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_  
 Marital Status: S M D W Number of Children: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Spouse's Age: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_  
 Spouse's Occupation: \_\_\_\_\_ Spouse's Social Security Number: \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Spouse's Phone (Work): \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_ Insured's Phone: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Spouse's Insurance Company: \_\_\_\_\_  
 How did you hear about this office: \_\_\_\_\_ Referred by: \_\_\_\_\_  
 Past Chiropractic Care: Yes No When? \_\_\_\_\_ Doctor's Name: \_\_\_\_\_ Results: \_\_\_\_\_

Are your present problems due to an injury? Yes No On Job Auto Accident Personal Injury Other: \_\_\_\_\_  
 Has the accident been reported? Yes No To Employer Auto Carrier Other: \_\_\_\_\_  
 Are you now or have you ever been disabled? (Service or Work)? Yes No When? \_\_\_\_\_  
 Have you retained an attorney? Yes No Name & Address: \_\_\_\_\_

#### What is your current work status?

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Full time, no restrictions   | <input type="checkbox"/> Full time, restrictions | <input type="checkbox"/> Full time Homemaker | <input type="checkbox"/> Full time student |
| <input type="checkbox"/> Part time, no restrictions   | <input type="checkbox"/> Part time, restrictions | <input type="checkbox"/> Retired             | <input type="checkbox"/> Unemployed        |
| <input type="checkbox"/> Off work due to restrictions | <input type="checkbox"/> Other _____             |  |  |

#### Restrictions:

Off work: Yes No Previously From: \_\_\_\_\_ to \_\_\_\_\_  
 Light duty: Yes No Previously (If yes, what are/were your restrictions?) \_\_\_\_\_  
 Do/did you require outside help at home? Yes No (If yes, what help do/did you need?) \_\_\_\_\_

List any accidents or falls and dates: Auto: \_\_\_\_\_ Recreation: \_\_\_\_\_  
Sports: \_\_\_\_\_ Work Related: \_\_\_\_\_ Other: \_\_\_\_\_  
 List any broken bones (fractures) or dislocations: \_\_\_\_\_  
 Ever on crutches? Yes No Why? \_\_\_\_\_  
 Were you ever knocked unconscious? Yes No (If yes, please explain): \_\_\_\_\_  
 Have you ever had X-rays taken? Yes No When? \_\_\_\_\_ By Whom? \_\_\_\_\_  
 For what ailments were these X-rays made? \_\_\_\_\_  
 Do you wear orthotics or heal lifts? Yes No Fitted by whom? \_\_\_\_\_ When? \_\_\_\_\_  
 Do you suffer from any condition other than that for which you are now consulting us? Yes No \_\_\_\_\_  
 Are you presently taking any medication, prescription, over-the-counter, home remedies, vitamins, minerals, etc?  
 (Please list) \_\_\_\_\_

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider will prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

**Patient's/Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

DATE: \_\_\_\_\_  
 ACCT: \_\_\_\_\_  
 PATIENT: \_\_\_\_\_

## PATIENT HISTORY

1. What is your **main complaint**? \_\_\_\_\_
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

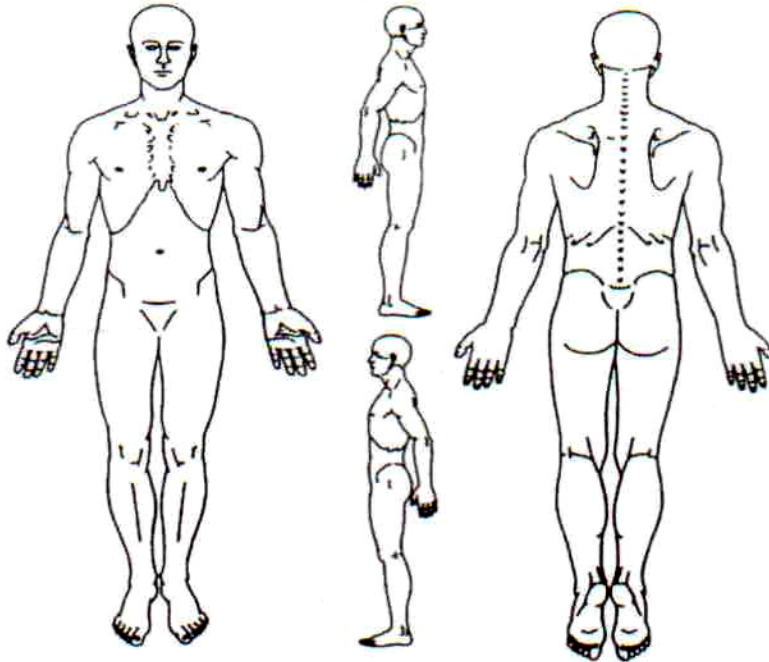
None	Slight			Mild		Moderate		Severe	
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint**:

Occasional				Intermittent				Frequent		Constant	
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint**? \_\_\_\_\_
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

**A:** ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

- personal care \_\_\_\_\_
- lifting \_\_\_\_\_
- reading \_\_\_\_\_
- concentrating \_\_\_\_\_
- work \_\_\_\_\_
- driving \_\_\_\_\_
- sleeping \_\_\_\_\_
- recreation \_\_\_\_\_
- walking \_\_\_\_\_
- sitting \_\_\_\_\_
- standing \_\_\_\_\_
- social life \_\_\_\_\_

6. When do you notice it most?  AM  PM  
 How long does it last? \_\_\_\_\_ Mins \_\_\_\_\_ Hrs
7. What makes it feel better? \_\_\_\_\_
8. What makes it feel worse? \_\_\_\_\_
9. Have you ever had this problem in the past?  Yes  No
10. I have  been hospitalized  been treated by another chiropractor  
 been treated by another specialty provider  never received care for this problem.
11. Have you lost time from work because of it?  Yes  No  
 Dates? \_\_\_\_\_ to \_\_\_\_\_
12. Are you Pregnant?  Yes  No
13. What was the first day of your last menstrual cycle? \_\_\_\_\_
14. Number of pregnancies? \_\_\_\_\_ Miscarriages? \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

# EHR Record

Patient Name: \_\_\_\_\_ MRN: \_\_\_\_\_ Date: \_\_\_\_\_

## Family Medical History:

	Back Pain	Heart	Stroke	Cancer	Diabetes	High BP
Mother :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No. of Sisters :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No. of Brothers :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No. of Children :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Pre-Existing Conditions:

<input type="checkbox"/> Alcohol/drug addiction	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Backaches	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Blood clots
<input type="checkbox"/> Blood transfusions	<input type="checkbox"/> Bowel Problems	<input type="checkbox"/> Broken bones	<input type="checkbox"/> Cancer
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Colitis	<input type="checkbox"/> Collagen vascular disease
<input type="checkbox"/> Constipation	<input type="checkbox"/> Depression/anxiety	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Digestive Disorders
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Female Health Challenges	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Genital Herpes
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Gout	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Disease/Attacks
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High Blood pressure
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Joint/back pain	<input type="checkbox"/> Kidney infections
<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Liver disease/problems	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Mental disorder
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio	<input type="checkbox"/> Prostate problems	<input type="checkbox"/> Reflux/ulcers
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Seizures/epilepsy	<input type="checkbox"/> Sexual dysfunction	<input type="checkbox"/> Sickle cell
<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Stress/Tension	<input type="checkbox"/> Stroke	<input type="checkbox"/> Suicidal tendencies
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumors	<input type="checkbox"/> Urine discoloration

Social / Everyday:

	Daily	3x/wk	2x/wk	1x/wk	2x/mo	1x/mo	Never
Tobacco/Smoke :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work on a Computer :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit at a Desk :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work on a Phone :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholic beverages :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moderate/Heavy labor :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stay at home :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deliver packages :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Surgeries within the past 12 months: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_