

### Patient History

Name: \_\_\_\_\_ Address \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_ Sex M F  
 Social Security#: \_\_\_\_\_ Drivers License # \_\_\_\_\_  
 Insurance #: \_\_\_\_\_ Circle one: Single Married Divorced Widowed Separated  
 Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Spouses Social # \_\_\_\_\_  
 Spouse Name: \_\_\_\_\_ Spouses Insurance # \_\_\_\_\_  
 Spouse Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Type of Work \_\_\_\_\_ Name & Ages of Children \_\_\_\_\_  
 Referred to this office by: \_\_\_\_\_  
 Name & Number of Emergency Contact \_\_\_\_\_  
 Who is responsible for your bill? You and  Spouse  Worker's comp  Auto Insurance  Medicare  
 E-mail Address \_\_\_\_\_ Cell phone: \_\_\_\_\_

### Current Health Condition

Your health Concern: \_\_\_\_\_  
 Other Doctors seen for this yes No Who? \_\_\_\_\_  
 Type of Treatment \_\_\_\_\_ Results \_\_\_\_\_  
 When did this begin? \_\_\_\_\_ Has it occurred before yes No  
 Is Condition:  Job Related  Auto Accident  Home Injury  Fall  Other \_\_\_\_\_  
 Date of Accident \_\_\_\_\_ Time Of Accident \_\_\_\_\_ Reported to employer Y N  
 What drugs to you take?  Nerve pills/antidepressants  Pain killers/Muscle relaxers  
 Blood Pressure Medication  Insulin  Other \_\_\_\_\_  
 \_\_\_\_\_  
 Do you have any other condition other than that which you are consulting us? \_\_\_\_\_

### Past Health History

Major Surgery/Operations:  Appendectomy  Tonsillectomy  Gall Bladder  
 Hernia  Back Surgery  Broken Bones  Other \_\_\_\_\_  
 Major falls or Accidents: \_\_\_\_\_  
 \_\_\_\_\_  
 Hospitalization (Other than above): \_\_\_\_\_  
 \_\_\_\_\_  
 Previous Chiropractic Care:  N  Y Doctor's Name & Last visit date \_\_\_\_\_  
 \_\_\_\_\_

Below are a list of diseases which may seem unrelated to the purpose of your Appointment. However, these questions must be answered carefully as these problems can affect the overall course of your care.

**Check any of the Following Diseases you have had ever:**

- |  |  |   |                                      |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Influenza        | <b>INTAKE</b>                        |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox     | <input type="checkbox"/> Pleurisy         | <input type="checkbox"/> Coffee      |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Tea         |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Alcohol     |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes  |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago          | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Thyroid       | <input type="checkbox"/> Eczema           |                                      |

Have you tested positive for HIV?  yes  No

**Check Any of the Following You had the Past 6 Months:**

**MUSCULO-SKELETAL**

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Jaw Clicks
- General Stiffness

**NERVOUS SYSTEM**

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

**GENERAL**

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

**Gastro-Intestinal**

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver problems
- Gall Bladder Trouble
- Weight Trouble
- Abdominal Cramps

- Gas/Bloating
- Heartburn
- Black/Bloody Stool
- Colitis

**GENITO-URINARY**

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

**CARDIO- PULMONARY**

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heart Beat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

**EENT**

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose/Sinus Problems

**MALE/FEMALE**

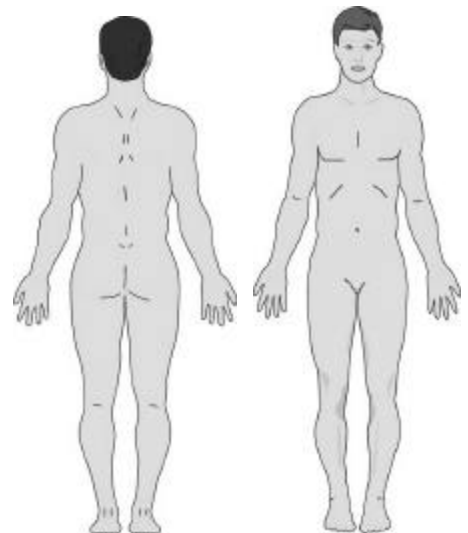
- Menstrual Irregular
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostrate Problems
- Impotent
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**FEMALES ONLY**

When was you last Period? \_\_\_\_\_

Are you Pregnant?

- Yes  No  Not Sure



Please outline on the diagram the area of discomfort.

**FAMILY HISTORY**

The following family have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

