Adult
Minor Child

Patient History

Please fill in the appropriate spaces (all information is confidential)

What do you prefer to be called:
Name: (Last) ________________________ (First) __________________________________ (MI) ___________
Address: ____
City: __________________________ State: _______________________ Zip: _________________

Date of Birth: _________________ Your Age: ___________
Patient Social Security #: __________________________ Married Single Divorced Widowed
Home Phone #: _________________________________ Work Phone #: ______________________________
Cell Phone #: __________________________________ Email Address: ______________________________
Patient's Employer: ______________________________ Retired Unemployed Student
Employer's Address: ____ Occupation: ____________________
Spouse's Name: _________________________________ Spouse's Social Security #: ______________________
Spouse's Date of Birth: ____________________________
Spouse's Occupation: ______________________________ Spouse's Employer: ___________________________
Do you have children? Yes / No How many? ________ Ages of Children: _____________________________
Who may we thank for referring you? __________________ Social Media friend/ family Website

Name of Person Responsible for this account: __________________________ Relationship to Patient: ___________

IN EVENT OF EMERGENCY

Who should we contact? __________________________ Relationship to You: ____________________________
Phone #: __________________________ Address: ____

MAIN COMPLAINT

Please Describe your MAIN complaint:

____
____

Date when symptoms first appeared: __________________ How long have you had it? ________ Days / Mos. / Yrs.
Did it begin _____ Gradually _____ Suddenly _____ Progressed over time
How did it happen: ____
Have you been treated by another Chiropractor/ Physician for the same condition? No Yes Name: ___________
What makes the symptoms worse? Driving Lifting Walking Morning/Evening Lying Down Bending Sitting
Other: ____
What relieves the symptoms worse? Rest Sitting Lying Down Exercise/Stretching Heat/Cold Morning/Night
Other: ____
Type of Pain: _____ Dull / Achy _____ Sharp / Stabbing _____ Burning _____ Throbbing _____ Electrical
Does the pain radiate into your: _____ Arms _____ Legs _____ Head _____ Does not radiate
Do you experience numbness or Tingling? _____ Y ______ N Where? __________________________________
What activities (if any) does this condition stop you from doing? *Sleeping Exercising Sitting Standing Lying Down Walking Lifting Turning Driving Other*: ____
Do you experience this pain every day? _____ Y _____ N How often do you experience these symptoms?
_____ 100% (Constantly) ______ 75% (Most of the day/night) _____ 50% (Half the day/night) _____ 25% (Occasionally)

PAIN INTENSITY: Please put a check mark on the scale describing the intensity of your pain right now.
No Pain 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ Unbearable Pain

What results do you hope to obtain in our office? (Check all that apply)
____ Relief Care: Relief from pain and symptoms to be more comfortable.
____ Corrective Care: Go beyond relief from pain and correct the problem at it's source.
____ Wellness Care: Maintain the care you've received. Focus on your health, wellness and prevention.

Please rate your level of commitment to achieving your wellness goals:
0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____

CONFIDENTIAL HEALTH HISTORY

Dominant Hand: Right Left Both For Women Only: Are you pregnant? ____ Y ____N (initial)

Have you ever had surgery or been hospitalized? Yes / No

List Surgeries:____

Please list any past serious accidents, injuries, or motor vehicle accidents with dates: ____________________________

____

Please list any medications, vitamins or supplements you are currently taking:

____

____

Please list anything that you may be allergic to: ____

Do you have, or have you ever had any of the following health problems? (*Check all that apply)*

____ Headaches	____ Achyness /General Pain	____ High/ Low Blood Pressure	____ Auto Accidents
____ Migraine	____ Difficulty Concentrating	____ Excessive Sweating	____ Other Accidents/ Falls
____ Neck Pain/Stiffness	____ Memory Loss/ Forgetful	____ Stomach Problems	____ Sports Injuries
____ Shoulder Pain/Stiffness	____ Frequent Colds/ Flu	____ Nausea	____ Work Injuries
____ Numbness/ Tingling Arm(s)	____ Nervousness	____ Ulcers	____ Fainting
____ Elbow Pain/ Stiffness	____ Irritability	____ Liver/ Gall Bladder Problems	____ Depression
____ Wrist/ Hand Pain or Stiffness	____ Diabetes	____ Kidney Problems	____ Mood Disorders
____ Upper Back Pain or Stiffness	____ Cancer	____ Digestion Problems	____ Emotional Disorders
____ Mid Back Pain or Stiffness	____ Vision/ Eye Problems	____ Diarrhea	____ Tension
____ Low Back Pain or Stiffness	____ Hearing/ Ear Problems	____ Constipation	____ Stress
____ Hip Pain or Stiffness	____ Ear Infections	____ Bladder Problems	____ Anxiety
____ Knee Pain or Stiffness	____ Sinus Problems	____ Incontinence	____ Poor Diet
____ Ankle/ Foot Pain or Stiffness	____ Thyroid Problems	____ Impotence	____ Pain w/ Coughing
____ Pain Shooting down leg(s)	____ Allergies	____ Prostate Problems	____ Pain w/ Sneezing
____ Trouble Walking	____ Asthma	____ Bed Wetting	____ Pain at stools
____ Sore Muscles	____ Trouble Breathing	____ Menstrual Problems (PMS)	____ Restricts Daily Activity
____ Painful joints	____ Heart Problems	____ Fractured Bones	____ Restricts Exercise
____ Tiredness/ Fatigue	____ Circulation Problems	____ Dizziness	____ Unable to Work

____ Other Problems not listed: ____

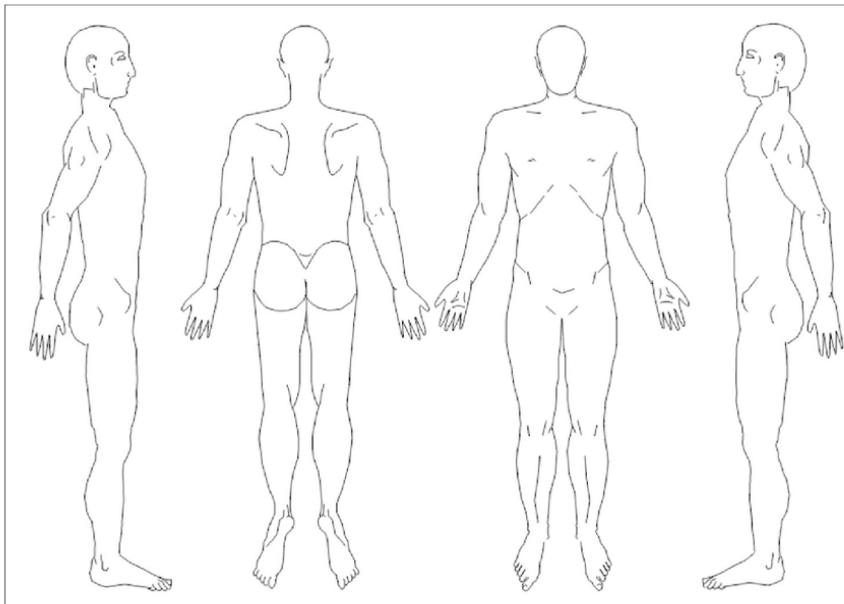
Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes	Other: ____________________
Father's Side	☐	☐	☐	☐	
Mother's Side	☐	☐	☐	☐	

Doctors seen in the last year: ____

PAIN LOCATION

Please mark off the areas of your complaint(s) on the diagram. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP Pain
NNN Numbness
TTT Tingling
BBB Burning
CCC Cramping



PATIENT'S SIGNATURE ____DATE ________________

OFFICE SIGNATURE ____DATE ________________