Patient History

Name_____ Date_____
Address_____ State_____ Zip_____
H. Phone (_____)_____ W. Phone_____ Date of Birth_____ Age_____
Referred by_____Social Security #_____
Occupation_____Employer_____
Marital Status S M D W Spouse Name_____
Number of Children/Ages_____ Spouses Occupation_____
Have you ever received Chiropractic Care? Yes No

Insurance Information

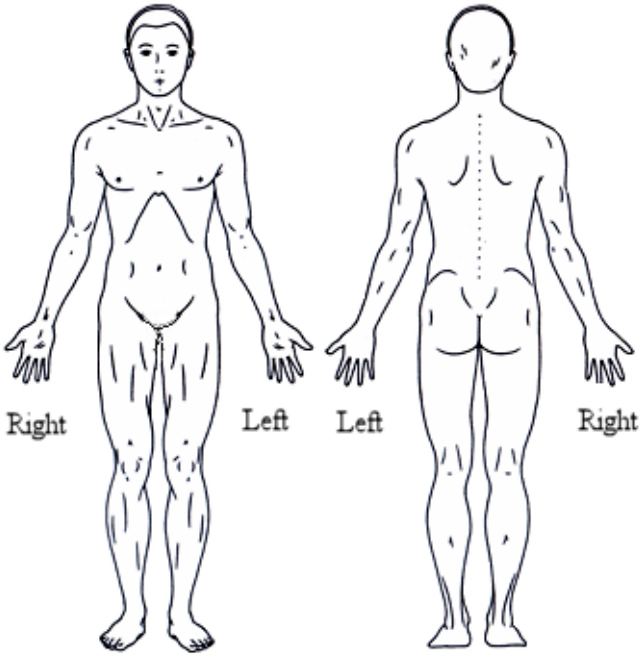
Insurance Company _____ ID Number_____ Group Number _____
Are you the subscriber? Yes No
If no, please fill out the following information.
Subscriber Name _____ Date of Birth _____ Relation to subscriber _____
Subscriber's Address _____ State _____ Zip _____

Please circle for each of the following:		Patient Comment If answer is Yes	Chiropractor's Comments
1. Regarding your Birth Process:			
Was the delivery long/difficult?	Y N	_____	_____
Forceps or extraction used?	Y N	_____	_____
Cesarean/ C-Section?	Y N	_____	_____
Breach/ cephalic?	Y N	_____	_____
Home birth?	Y N	_____	_____
Hospital birth?	Y N	_____	_____
Mother given drugs during delivery?	Y N	_____	_____
Was labor induced?	Y N	_____	_____
2. Growth and Development/ Childhood:			
Were you breast fed?	Y N	_____	_____
Health education?	Y N	_____	_____
Childhood illnesses?	Y N	_____	_____
Ear infections/ Colic/ Asthma?	Y N	_____	_____
Attention Deficit?	Y N	_____	_____
Antibiotics?	Y N	_____	_____
Drugs, prescription, OTC, recreational?	Y N	_____	_____
Surgery?	Y N	_____	_____
Hospitalizations?	Y N	_____	_____
Sports or other physical activities	Y N	_____	_____
Injuries during sports?	Y N	_____	_____
Auto accidents?	Y N	_____	_____
Did you have other traumas?	Y N	_____	_____
Did you ever break any bones?	Y N	_____	_____
3. Current Health Habits:			
Did/do you smoke?	Y N	_____	_____
Did/do you drink alcohol?	Y N	_____	_____
Diet, do you eat healthy foods?	Y N	_____	_____
Have you been in accidents/trauma?	Y N	_____	_____
Have you had surgery?	Y N	_____	_____
Drugs, prescription, OTC, recreational?	Y N	_____	_____
Dental problems?	Y N	_____	_____
Eye problems?	Y N	_____	_____
Hearing problems?	Y N	_____	_____
Exercise regularly?	Y N	_____	_____
Did/do you have occupational stress?	Y N	_____	_____
Drive? Daily time spent driving	Y N	_____	_____
Physical stress?	Y N	_____	_____
Emotional/Mental stress?	Y N	_____	_____
Hobbies/Sports injuries?	Y N	_____	_____

Do you sleep well, hours of sleep? Y N _____ _____
Sleeping posture? O side O stomach O back _____ _____

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office:
Major_____
Pain or Problem started on_____
Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____
Does this pain shoot, radiate, or travel in your body? Where?_____
Are you experiencing numbness or tingling in any area of your body? Where?_____
Since it began, is it: O Same O Better O Worst
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day?_____
Is this condition interfering with Work?_____ Sleep?_____Routine?_____Other?_____
Is this condition progressively getting worse?_____
Other Doctors seen for this condition_____
Any home remedies? _____
Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Using the symbols below, mark on the pictures where you feel pain.



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

Please mark any of the following conditions or symptoms that you have now or have experienced:
Other Symptoms:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps

O Jaw/TMJ Problems O Cold Feet O Menopause

Are you under medical care for any condition?_____
What Medications are you taking?_____
How long?_____ Have you had surgery?_____ What?_____ When?_____
What side effects have you experienced from the drugs and surgery?_____
Females Only – Date last Menstrual Period began on_____ Are you possibly Pregnant?_____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.
Patient Signature_____Date_____