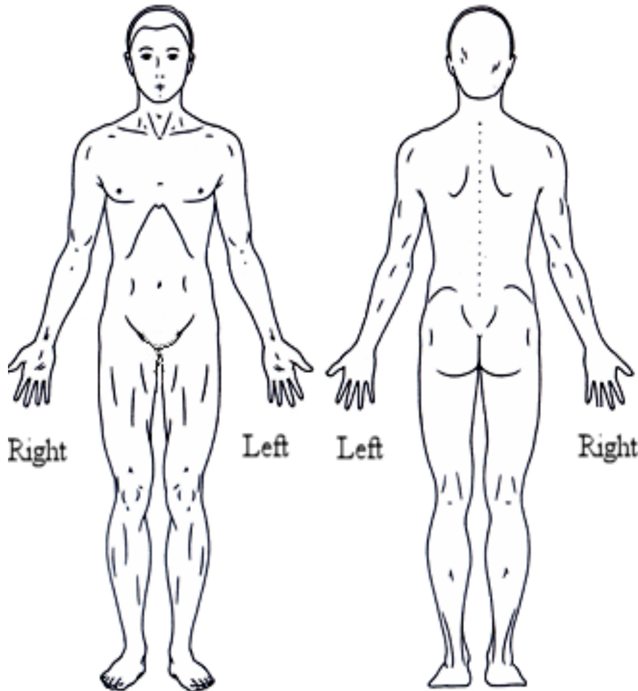
Confidential Patient History

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____________________
Have you ever received Chiropractic Care? Yes No

Please circle for each of the following:		Patient Comment If answer is Yes	Chiropractor's Comments
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	____________	____________
Have you been in accidents/trauma?	Y N	____________	____________
Have you had surgery?	Y N	____________	____________
Drugs, prescription, OTC, recreational?	Y N	____________	____________
Did/do you have occupational stress?	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______________________________
Has this pain or problem occurred before in your life? __________ When was it's earliest occurrence?__________
Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other______________
Pain is: Mild 1 2 3 Moderate 4 5 6 Severe 7 8 9 10. When it flares to its worst it is 1 2 3 4 5 6 7 8 9 10
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?______________________________

Is this condition interfering with Work?__________
Sleep?__________Routine?_______Other?______________________
Is this condition progressively getting worse?______________________________

Other Chiropractors or Medical Doctors seen for this condition______________________________

Mark on the pictures where you feel pain, numbing, tingling, or muscle spasm.

(See second page)

Second major Complaint/Reason for Seeking Care in this Office:
Major____
Pain or Problem started on____
Has this pain or problem occurred before in your life? ___________ When was it's earliest occurrence?_______________
Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other______________________
Pain is: Mild 1 2 3 Moderate 4 5 6 Severe 7 8 9 10. When it flares to its worst it is 1 2 3 4 5 6 7 8 9 10
Does this pain shoot, radiate, or travel in your body? Where?____

Third Complaint/Reason for Seeking Care in this Office:
Major____
Pain or Problem started on____
Has this pain or problem occurred before in your life? ___________ When was it's earliest occurrence?_______________
Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other______________________
Pain is: Mild 1 2 3 Moderate 4 5 6 Severe 7 8 9 10. When it flares to its worst it is 1 2 3 4 5 6 7 8 9 10
Does this pain shoot, radiate, or travel in your body? Where?____
Any other complaints/concerns?____

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

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

Do you have health coverage? If yes, with which carrier?____

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__________________________