

PATIENT HISTORY

Date: _____ Referred by: _____

Name: _____ Home #: _____ Cellular: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Sex: MF Age: _____ Marital Status : S D M # of Children: _____

Occupation/ Employer: _____ Work #: _____

Social Security #: _____ Driver's License #: _____

Primary Care Physician Name: Dr. _____

PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is confidential):

MAJOR COMPLAINT: _____

How long have you had this condition? _____ Date began: _____
Have you lost work days? Yes () No () How many? _____
Have you had this similar condition before? Yes () No () When? _____
Was the injury related to : work accident () auto accident ()
When did you last see a chiropractor: _____ Dr: _____
Why did you see this chiropractor? _____ Were you helped? _____

Did you follow it? Yes () No () If not, why? _____
Why are you changing chiropractors? _____

PAST (0) OR PRESENT (X) CONDITIONS:

- | | | |
|--|--|--|
| <input type="checkbox"/> Fractured Bones
<input type="checkbox"/> Auto Accidents
<input type="checkbox"/> 0-1 years ago
<input type="checkbox"/> 1-5 years ago
<input type="checkbox"/> 5 + years ago
<input type="checkbox"/> Other Accidents/Falls
<input type="checkbox"/> Knocked Unconscious
<input type="checkbox"/> Back Curvature
<input type="checkbox"/> Mental or Emotional Disorders
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Swollen or Painful Joints
<input type="checkbox"/> Convulsions/Epilepsy
<input type="checkbox"/> Skin Problems
<input type="checkbox"/> Itching
<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Cancer
<input type="checkbox"/> Frequent Colds/Flus
<input type="checkbox"/> Nervous
<input type="checkbox"/> Tension
<input type="checkbox"/> Depressed
<input type="checkbox"/> Irritable
<input type="checkbox"/> Anemia
<input type="checkbox"/> Excess Sweating
<input type="checkbox"/> Tremors
<input type="checkbox"/> Light Bothers Eyes
<input type="checkbox"/> Under Stress
<input type="checkbox"/> Crave Sweets or Salts
<input type="checkbox"/> Eating Disorders
<input type="checkbox"/> Trouble Sleeping
<input type="checkbox"/> Trouble Concentrating
<input type="checkbox"/> Loss of Memory
<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Chest Pain
<input type="checkbox"/> Mistake sidedness(R from L)
<input type="checkbox"/> Stutter
<input type="checkbox"/> Dyslexia
<input type="checkbox"/> Mood Changes
<input type="checkbox"/> Lose Temper easily
<input type="checkbox"/> Headache
<input type="checkbox"/> Neck pain or stiff R. L.
<input type="checkbox"/> Numbness, tingling, or pain in arms, hands, fingers R. L.
<input type="checkbox"/> Jaw pain or click (T.M.J.) R. L.
<input type="checkbox"/> Head seems too heavy
<input type="checkbox"/> Head & Shoulders feel tired
<input type="checkbox"/> Difficulty in excessive standing, walking, sitting, riding, bending, lifting, twisting, household duties
<input type="checkbox"/> Shoulder pain R. L.
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Ringing in ears R. L.
<input type="checkbox"/> Bearing Loss R. L.
<input type="checkbox"/> Fainting
<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Blurred or Double Vision R.L.
<input type="checkbox"/> Upper back pain or stiffness R. L.
<input type="checkbox"/> Mid back pain or stiffness R. L.
<input type="checkbox"/> Lower back pain or stiffness R.L.
<input type="checkbox"/> Numbness, tingling or pain in buttocks, thighs, legs, feet, toes R. L
<input type="checkbox"/> Pain with cough, sneeze or strain stools
<input type="checkbox"/> Hip pain R.L.
<input type="checkbox"/> Foot Trouble
<input type="checkbox"/> Asthma
<input type="checkbox"/> Lung Problems | <input type="checkbox"/> Wheezing
<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Stroke
<input type="checkbox"/> High or Low blood pressure
<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Liver Trouble
<input type="checkbox"/> Gall Bladder trouble
<input type="checkbox"/> Digestive Problems
<input type="checkbox"/> Excessive Gas
<input type="checkbox"/> Belching/bloating after meals
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Diarrhea/Constipation
<input type="checkbox"/> Colon Trouble
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Impotence
<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Discharge
<input type="checkbox"/> Menstrual Problems/ PMS
<input type="checkbox"/> Menopausal Problems
<input type="checkbox"/> Breast lumps, soreness, discharge
<input type="checkbox"/> Pregnant: _____ weeks/months
<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> AIDS/HIV

_____ |
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