

Patient History Form

Name: _____

Cardiovascular _____ No
Present Past No

| | | | |
|---------------------|--|--|--|
| Poor Circulation | | | |
| High BP | | | |
| Aortic Aneurism | | | |
| Heart Disease | | | |
| Chest Pain | | | |
| High Cholesterol | | | |
| Pace Maker | | | |
| Jaw Pain | | | |
| Irregular Heartbeat | | | |
| Swelling of Legs | | | |

Genitourinary _____ No
Present Past No

| | | | |
|-------------------|--|--|--|
| Kidney disease | | | |
| Lower side pain | | | |
| Burning urination | | | |
| Blood in urine | | | |
| Kidney stone | | | |

Hematologic/Lymphatic: _____ No
Present Past No

| | | | |
|---------------|--|--|--|
| Hepatitis | | | |
| Blood Clots | | | |
| Cancer | | | |
| Easy Bruising | | | |
| Easy Bleeding | | | |
| Fever | | | |
| Chills/Sweats | | | |

Psychiatric: _____ No
Present Past No

| | | | |
|----------------|--|--|--|
| Depression | | | |
| Anxiety | | | |
| Unusual Stress | | | |

Constitutional: _____ No
Present Past No

| | | | |
|---------------------|--|--|--|
| Weight Loss/Gain | | | |
| Energy level | | | |
| Difficulty Sleeping | | | |

Respiratory: _____ No
Present Past No

| | | | |
|---------------------|--|--|--|
| Asthma | | | |
| Tuberculosis | | | |
| Shortness of Breath | | | |
| Emphysema | | | |
| Cold/Flu | | | |
| Cough/Wheezing | | | |

Ears/Nose/Throat: _____ No
Present Past No

| | | | |
|-----------------------|--|--|--|
| Dizziness | | | |
| Hearing Loss | | | |
| Sinus Infection | | | |
| Nosebleed | | | |
| Sore Throat | | | |
| Difficulty Swallowing | | | |
| Bleeding Gum | | | |

Eyes: _____ No
Present Past No

| | | | |
|----------------|--|--|--|
| Glaucoma | | | |
| Double Vision | | | |
| Blurred Vision | | | |

Integumentary: _____ No
Present Past No

| | | | |
|--------------|--|--|--|
| Skin Lesions | | | |
| Skin Ulcers | | | |
| Skin Disease | | | |
| Eczema | | | |
| Psoriasis | | | |
| Rashes | | | |

Endocrine: _____ No
Present Past No

| | | | |
|---------------------|--|--|--|
| Thyroid Disease | | | |
| Diabetes | | | |
| Hair Loss | | | |
| Menopausal Problems | | | |

Allergic/Immunologic: _____ No
Present Past No

| | | | |
|-----------------|--|--|--|
| Hives | | | |
| Immune Disorder | | | |
| HIV/AIDS | | | |
| Allergy shots | | | |
| Cortisone use | | | |

Gastrointestinal: _____ No
Present Past No

| | | | |
|------------------|--|--|--|
| Gallbladder | | | |
| Bowel problems | | | |
| Constipation | | | |
| Liver problems | | | |
| Ulcers | | | |
| Diarrhea | | | |
| Nausea/ Vomiting | | | |
| Bloody Stools | | | |
| Poor Appetite | | | |

Musculoskeletal: _____ No
Present Past No

| | | | |
|-----------------|--|--|--|
| Gout | | | |
| Arthritis | | | |
| Joint stiffness | | | |
| Muscle weakness | | | |
| Osteoporosis | | | |
| Broken Bones | | | |
| Joint replaced | | | |

Neurological: _____ No
Present Past No

| | | | |
|-------------------|--|--|--|
| Babinski | | | |
| Stroke | | | |
| Seizures | | | |
| Head Injury | | | |
| Brain aneurysm | | | |
| Numbness | | | |
| Severe Headaches | | | |
| Pinched nerves | | | |
| Parkinson's | | | |
| Carpal Tunnel | | | |
| Spinning/ Balance | | | |

Other: _____

Surgeries:

- | | | | |
|----------------------|-----------------------------|--------------------------|-----------------------------------|
| __ Appendectomy | __ Cardiovascular procedure | __ Disc Procedure | __ Hysterectomy |
| __ Joint Replacement | __ Laminectomies | __ Radical prostatectomy | __ Transurethral prostate surgery |

Patient History Form

Allergies:

Eggs Fish & Shellfish Milk or Lactose Peanut
 Soy Sulfites Wheat/ Gluten Other _____

Social History:

Caffeine used occasionally Stress occasionally Chew tobacco occasionally Exercise often
 Caffeine used often Stress often Chew tobacco often Exercise occasionally
 Drink Alcohol Occasionally Smoke >1 pack per day Wear seat belt Never Exercise not at all
 Drink Alcohol often Smoke 1 pack or less Wear seat belt Always Wear seat belt usually

Family History

Arthritis (parent) Arthritis (sibling) Cancer (parent) Cancer (sibling)
 Cholesterol (parent) Cholesterol (sibling) Diabetes (parent) Diabetes (sibling)
 Heart problem (parent) Heart problem (sibling) High BP (parent) High BP (sibling)
 Psychiatric (parent) Psychiatric (sibling) Stroke (parent) Stroke (sibling)
 Thyroid (parent) Thyroid (sibling) Other _____

Substance Use:

Alcohol (past) Alcohol (present) Amphetamines (past) Amphetamines (present)
 Barbiturates (past) Barbiturates (present) Cocaine (past) Cocaine (present)
 Crystal Meth (past) Crystal Meth (present) Heroin (past) Heroin (present)
 Marijuana (past) Marijuana (present)

Male Children :

Under 6 years Under 10 years Under 19 years

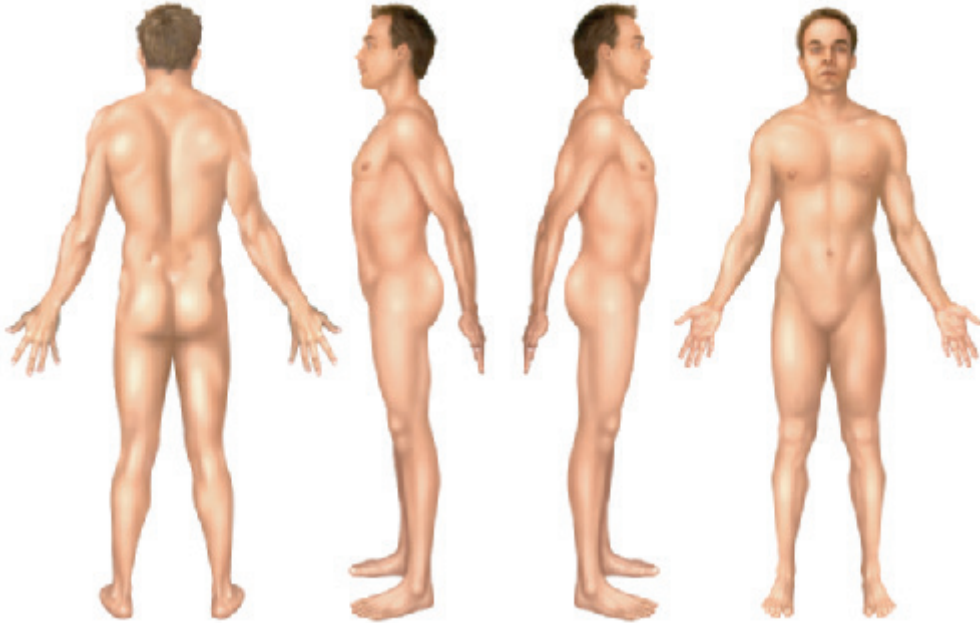
Female Children:

Under 6 years Under 10 years Under 19 years

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

= Numbness X = Burning / = Stabbing 0 = Pins & Needles + = Dull Ache

Patient History Form



Describe your symptoms: _____

When did you symptoms start? Month _____ Day _____ Year _____

How did your symptoms begin? _____

How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- Sharp
- Dull ache
- Numb
- Shooting
- Burning
- Tingling
- Stabbing

How are your symptoms changing?

- Getting better
- Not Changing
- Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0=None to 10=Unbearable)

- 0 None
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Unbearable

During the past 4 weeks, how much pain interfered with your normal work (including work outside the home and housework)

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

In general, would you say your overall health right now is...

Patient History Form

Excellent Very good Good Fair
 Poor

Who have you seen for your symptoms:

No one Other Chiropractor Medical Doctor Physical Therapist
 Other _____

What treatment did you receive for your symptoms?

Adjustments Physical Therapy Medication Surgery
 Other _____

When did you receive this treatment?

In the last month 2-3 months ago 3-6 months ago 6 months to 1 year ago
 1-2 years ago 2-5 years 5-10 years

What tests have you had for your symptoms?

X-rays MRI CT scan Other _____

Have you had similar symptoms in the past?

Yes No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

This office Other chiropractor Medical Doctor Physical Therapist
 Other _____