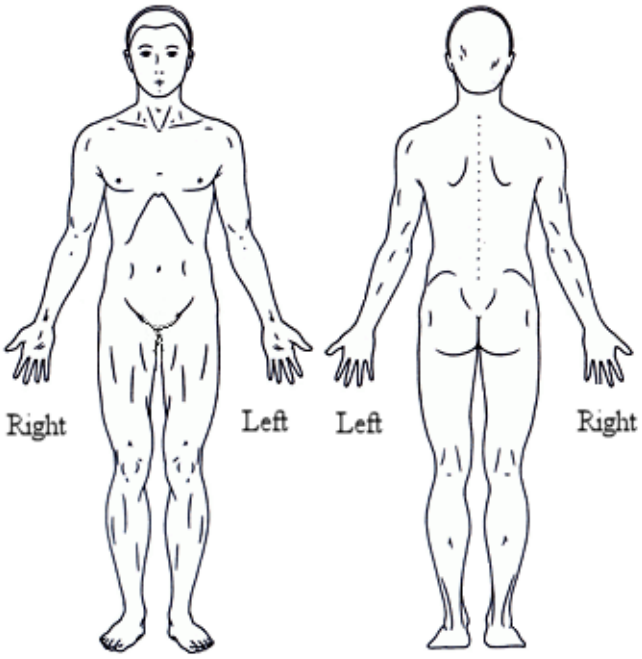
Patient History

Name_____ Date of Birth _____
Address_____ City_____ State_____ Zip_____
H. Phone _____ C. Phone_____ Email _____
Referred by_____ Occupation_____
Marital Status S M D W Spouse Name_____ Spouses Occupation_____
Number of Children/Ages_____ Have you ever received Chiropractic Care? Yes No

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office: _____
Pain or Problem started on_____ 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?_____
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 _____	^ ^ ^

Are you under medical care for any condition? Yes No Please Specify: _____
What Medications are you taking?_____
How long?_____ Have you had surgery? Yes No For what?_____ When?_____
What side effects have you experienced from the drugs and surgery?_____
Did/do you smoke? Yes No How often? _____ Did/do you drink alcohol? Yes No How often? _____
Have you been in accidents/trauma? Yes No Have/do you use drugs, OTC, recreational? Yes No How often? _____
Do you have dental problems? _____ Do you have eye problems? _____
Do you have hearing problems? _____ Do you exercise regularly? _____
Do you have occupational stress? Please explain: _____
Do you have physical stress? _____ Do you have emotional/mental stress? _____
How much time a day do you spend driving/in your car? _____ Injuries due to hobbies/sports? _____
Do you sleep well? Yes No How many hours of sleep do you get a night? _____ Sleeping posture? __side __stomach __back

Please mark each item below for each sign or symptom you presently have or previously had:

General Symptoms
___ Convulsions
___ Dizziness
___ Fainting
___ Headache
___ Nervousness
___ Numbness
___ Wheezing

Muscles & Joints
___ Low Back Problems
___ Pain Between Shoulders
___ Neck Problems
___ Arm Problems
___ Leg Problems
___ Swollen Joints
___ Painful Joints
___ Stiff Joints
___ Sore Muscles
___ Weak Muscles
___ Walking Problems
___ Sprains/Strains
___ Broken Bones

Cardiovascular
___ High Blood Pressure
___ Heart Attack
___ Pain Over Heart
___ Poor Circulation
___ Heart Trouble
___ Rapid Heart
___ Slow Heart
___ Strokes
___ Swelling Ankles
___ Varicose Veins

Ear/Nose/Throat
___ Earache
___ Ear Noises
___ Enlarged Thyroid
___ Frequent Colds
___ Hay fever
___ Nasal Blockage
___ Nose Bleeds
___ Pain Behind Eyes
___ Poor Vision
___ Sinusitis
___ Sore Throats
___ Tonsillitis

Gastro-Intestinal
___ Belching/Gas
___ Colon Problems
___ Constipation
___ Diarrhea
___ Excessive Hunger
___ Excessive Thirst
___ Gall Bladder Trouble
___ Hemorrhoids
___ Liver/Gallbladder
___ Nausea
___ Abdominal Pain
___ Ulcer
___ Poor Appetite
___ Poor Digestion
___ Vomiting
___ Vomiting Blood
___ Black Stool
___ Bloody Stool
___ Weight Gain/Loss

Respiratory
___ Asthma
___ Chronic Cough
___ Difficulty Breathing
___ Spitting Blood
___ Spitting Phlegm

Genito-Urinary
___ Blood in Urine
___ Frequent Urination
___ Kidney Infection
___ Painful Urination
___ Prostate Problems
___ Loss of Bladder Control

Skin or Allergies
___ Boils
___ Bruising Easily
___ Dryness
___ Eczema/Rash/Dermatitis
___ Hives
___ Itching
___ Sensitive Skin
___ Allergy _____

For Women Only
___ Birth Control
___ Hormone Replacement
___ Cramps/Backaches
___ Excessive Flow
___ Hot Flashes
___ Irregular Cycle
___ Miscarriage
___ Painful periods
___ Vaginal Discharge
___ Breast Pain

Are you now or could you be pregnant? Yes No

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_____