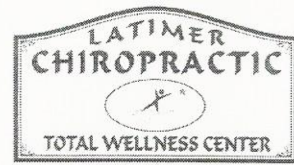
LATIMER CHIROPRACTIC / PAMELA G. LATIMER D.C.



PATIENT HEALTH HISTORY

PLEASE ANSWER ALL QUESTIONS FULLY TO HELP THIS OFFICE SERVE YOU BETTER

NAME______________________________ **HOME PHONE**______________

MAILING ______________________ **STREET**________________________

CITY__________________ STATE____ ZIP__________ **SS#**________________

DATE OF BIRTH____________ **AGE**______ **CHILDREN**________ **AGES**____________

YOUR OCCUPATION______________ **NAME OF COMPANY**______________

If retired, what did you do? ____________________

WORK#________________ **CELL**______________ **CARRIER--Verizon, T-MOBILE,**etc ________

MARTIAL STATUS S M W Sep **SPOUSES NAME**________________

SPOUSES OCCUP________________ **NAME OF COMPANY**________________

EMERGENCY CONTACT____________________ **PHONE #**______________

WE HAVE INFORMATION TO GIVE YOU TO HELP YOU UNDERSTAND YOUR CONDITION AND HEAL MORE QUICKLY. DO YOU PREFER REGULAR MAIL OR EMAIL?

E-MAIL ADDRESS____

WHO CAN WE **THANK FOR REFERRING YOU TO THIS OFFICE?** ________________

LOCAL DOCTOR's NAME? ____________________ **LAST EXAM DATE**__________

HEALTH TREATMENTS (for what) IN THE LAST YEAR? ____________________

WHAT CAN WE HELP YOU WITH? ________________________________

____

DESCRIBE WHAT YOU ARE FEELING BY **MARKING THE INVOLVED BODY PARTS:**

Using the symbols below:

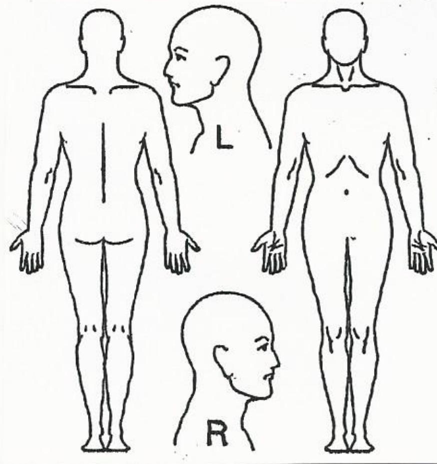
Numbness xxxxxx

Pins & needles ......

Burning 0000000

Aching ^^^^^^^

Stabbing //////////



MARK THE RANGE OF PAIN YOU ARE IN **Less pain** **1----------------------------------10** **Most pain**

HOW AND WHEN DID IT FIRST DEVELOP? ____________________________

HOW IS YOUR LIFE AFFECTED BY THIS PAIN? Sitting Standing Lifting Sleeping Walking Driving Reaching Carrying Twisting Squatting Other_______

WHAT RELIEVES the problem? Meds (for pain) _________ Ice Heat Exercise Rest _____

What AGGRAVATES the problem? ______________________________

MEDICATIONS YOU TAKE and purpose ______________________________

VITAMINS YOU TAKE ______________________________
EXERCISES YOU DO AND FREQUENCY? ______________________________
TREATED FOR THIS IN THE PAST? YES/NO BY WHOM ________________RESULTS ___________

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "**NONE**

Constitutional: NONE
- ☐ Chills/ Hot/Fever
- ☐ Daytime Drowsiness/ Fainting
- ☐ Weight Gain/Loss

Eyes/Vision: NONE
- ☐ Any issues_____

Ears, Nose, and Throat: NONE
- ☐ Dizziness/Ears/Pain/hearing
- ☐ Tinnitus (ringing in the ears)
- ☐ Headaches/Head Injury –history
- ☐ Nose/sinus symptoms
  Throat sore/hoarse/swallowing
- ☐ TMJ Disorder/pain/click

Respiration: NONE
- ☐ Breathing Issues

Cardiovascular: NONE
- ☐ Heart Problems
- ☐ Chest Pain
- ☐ Arm/leg pain or achiness/swelling
- ☐ Ulcers/Varicose Veins

Gastrointestinal: NONE
- ☐ Bowels/cramp/bleed/loose
- ☐ Appetite Changes/ Vomiting
- ☐ Heartburn/Indigestion/Nausea

Endocrine NONE
- ☐ Diabetes/Blood Sugar Problems
- ☐ Excessive Thirst/ Hunger
- ☐ Frequent Urination
- ☐ Hair Loss/ Growth
- ☐ Heat/ Cold Intolerance
- ☐ Voice Changes/ Lymph Node Swelling

Female/ Male: NONE
- ☐ Birth Control Therapy
- ☐ Breast Symptoms
- ☐ Urination Symptoms
- ☐ Hormone Therapy
- ☐ Menstruation Symptoms
- ☐ Vaginal/Penis Symptoms
- ☐ Prostate Symptoms

Skin: NONE
- ☐ Changes in skin color/texture
- ☐ Itching/ Rash/ Hives
- ☐ (numb/heat/tingling)
- ☐ History of Skin Disorders

Nervous System/ Psych: NONE
- ☐ Dizziness/ Headaches/Facial Weak/ Speech Symptoms
- ☐ Limb Weak/ Numb/ Tremors/Loss of Consciousness
- ☐ Loss of Memory/ Seizures/ Strokes
- ☐ Sleep Symptoms/ Insomnia
- ☐ Walking Issues
- ☐ Anxiety/Depression/Confusion/Behavioral Change(s)
- ☐ Bipolar/Depression/Mood Change(s)

Allergy: NONE
- ☐ Food Intolerance
- ☐ Itching/rash
- ☐ Nasal Congestion/ Sneezing
- ☐ Allergies

Hematology: NONE
- ☐ Anemia
- ☐ Bleeding/Clotting/Bruises Easily

PLEASE circle ALL THAT APPLY TO YOU OVER YOUR entire life AND GENERAL DATES.
AUTO ACCIDENTS ____________________SURGERIES__________________________
TRAUMA/FALLS ______________________
BROKEN BONES ____________________CONTACT SPORTS ____________________
ALCOHOL use ____________________HEAVY LIFTING JOBS ________________
DO YOU WEAR A SEAT BELT REGULARLY? Yes ___ No ___ Sometimes ______________

I give permission for the doctor to examine me and do all tests necessary, for my treatment at Latimer Chiropractic Total Wellness Center
PATIENT SIGNATURE______________________________________DATE____________

If minor NAME OF PARENT OR GUARDIAN _______________ PHONE (cell-OR-home) _________

I hereby authorize Pamela G. Latimer, D.C. and whomever she may designate to administer care as is deemed necessary to my **son/daughter/ward.PARENTS SIGNATURE_______________________**
DATE___________WITNESSED ________________________________