PATIENT HISTORY

Date: _____ Email Address: _____
Name: _____ Referred By: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ DOB: ___/___/___ Sex: ___ Marital Status: _____ # of Children ___
Occupation: _____ Employment: _____ Work Phone #: _____
SSN#: ___-___-____ Driver's License #: _____

MAJOR COMPLAINT: _____
Additional Complaints: _____
When did your symptoms begin: _____
How often do you symptoms occur? __Occasionally __Intermittent __Frequently __Constantly
Are you getting __Better __Worse __Same What aggravates your complaints? _____
What relieves your complaints? _____
Name other doctors you have seen for this complaint? _____
For how long and what was done? _____
Have you had this same complaint before? __ YES __ NO When? _____
Have you lost work days? __YES __NO How many? _____
Is this condition related to: __Work Accident __Auto Accident

ARE YOU PRESENTLY SUFFERING (OR WITH THE PAST SIX MONTHS SUFFERED) FROM ANY OF THE FOLLOWING?

GENERAL
__Fatigue
__Weakness
__Fever
__Chills
__Weight Change
__Night Sweats

EYES
__Vision Trouble
__Pain
__Discharge
__Other

MOUTH/THROAT
__Sore
__Bleeding
__Enlarged Glands
__Abdominal Pain
__Absence of Taste
__Abnormal Taste
__Tonsilitis

EARS
__Hearing Troubles
__Ringing
__Pain
__Discharge
__Other

BREASTS
__Lumps in Breasts
__Pain
__Redness/Itching
__Discharge
__Dimpling

NOSE
__Pain
__Bleeding
__Sinus Problems
__Infections
__Absence of Smell
__Other

SKIN
__Rash
__Redness
__Itchy
__Dryness
__Eczema
__Hair Changes
__Nail Changes
__Bruise Easily

CARDIO-VASCULAR -PULMONARY
__Cough
__Wheezing
__Difficulty Breathing
__Swollen Extremities
__Blue Extremities
__Varicosities
__Murmur
__Chest Pain
__Palpitations

GENITOURINARY
__Inability to Hold Urine
__Painful Urination
__Frequent Urination
__Bedwetting
__Irregular Menstruation
__Painful Menstruation
__Impotence
__Sterility
__Prostate Problems
__Other

PSYCHOLOGIC
__Anxiety
__Depression
__Memory Loss or Impairment
__Phobias
__Mood Swings
__Other

GASTRO INTESTINAL (STOMACH)
__Decreased Appetite
__Increased Appetite
__Hemorrhoids
__Excess Gas
__Vomiting
__Diarrhea
__Constipation

NEUROLOGIC
__Headaches
__Dizziness
__Fainting
__Convulsions
__Nervousness
__Other

ENDOCRINE
__Heat/Cold Intolerance
__Sugar in Urine
__Goiter
__Tremor
__Other

What hobbies do you participate in? _____
Are your current problems affecting these activities or hobbies? __Yes or __No
What activities are you looking to do after retirement? _____
How often do you exercise? (Days/weeks) __Never __1-2 __3-4 __5-6 __7-8
Have you ever been to a Chiropractor? __YES __NO
Do you have a Family Physician? __YES __NO Date of last physical exam? __/__/____
Physicians name and address_____
Have you had surgery in the past 5 years? __YES __NO Date and Reason for surgery _____

Have you been hospitalized in the past 5 years? __YES __NO Date and Reason _____
List any medication that you take (prescription and non-prescription)

_____

Do you have any drug allergies? __YES __NO List Drugs:_____

WOMEN ONLY

To your knowledge, are you pregnant? __YES __NO
Have your past pregnancies been normal? __YES __NO
Are you seeing an OB-GYN regularly? __YES __NO
Date of last exam:__/__/__ Physicians name and address:_____

PAST (0) or PRESENT (X) CONDITION

__Arthritis
__Asthma
__Sinus Trouble
__Hay Fever
__Allergies
__Tuberculosis
__Diabetes
__Epilepsy
__Thyroid Trouble
__High Blood Pressure
__Low Blood Pressure
__Heart Trouble
__Pace Maker
__HIV/ARC
__AIDS
__Sexually Transmitted Disease
__Ulcer
__Cancer
__Polo
__Rheumatic Fever
__Serious Injury
__Bone Fracture
__Dislocated Joints
__Spinal Disc Disease
__Multiple Sclerosis
__Scoliosis
__Mental/Emotional Disability
__Prostate Trouble
__Kidney Trouble

Other_____

FAMILY HISTORY OF:

__Cancer
__Diabetes
__Heart Trouble
__High Blood Pressure
__Stroke
__Osteoporosis
__Multiple Sclerosis
__Headaches
__Neck Problems
__Back Problems
__Disc Problems
__Joint Problems
__Arthritis
__Pinched Nerve
__Scoliosis
__Bad Posture

Who? _____

Do you work? __Full Time __Part Time __Temp. __Other
How many hours a day do you work? _____ How many days per week do you work? _____
Does your present condition affect the number of hours you work per week? __YES __NO
Length of time at present job? __Years __Months __Days
Are you right or left handed? _____
Does your job involve lifting? __NEVER __OCCASIONALLY __FREQUENT __CONSTANTLY
How many pounds? _____
Does your job involve __BENDING __TWISTING __CARRYING __STOOPING __TURNING __WALKING__OTHER_____
What is your primary work position/location? __SEATED __STANDING __DESK __ WORKBENCH __COUNTER __OTHER_____
If seated what type of chair do you use? __EXECUTIVE __STOOL __BENCH__OTHER_____
Do you wear shoes or boots with high heels? __NEVER __SELDOM __OCCASIONALLY __FREQUENTLY
Does your activity aggravate your present complaint? __YES __NO
Which best describes your stress level? __NONE __MINIMAL __MODERATE __GREAT
How do you rate your physical activity at work? __Light Manual Labor __Moderate Manual Labor __Heavy Manual Labor__
Is your spouse employed? __YES __NO Place of employment:_____

INSURANCE INFORMATION

Do you have Health Insurance? __YES __NO If so, what Insurance Company_____
Policy #_____ Group #_____
Policy Holder:_____
Are you covered by Medicare? __YES __NO Medicare ID# _____

How do you want us to handle your problem?
___Temporary Relief (help the symptoms but, not correct the problem)
___Maximum Correction (Correct the cause of the problem for maximum stability in the future)

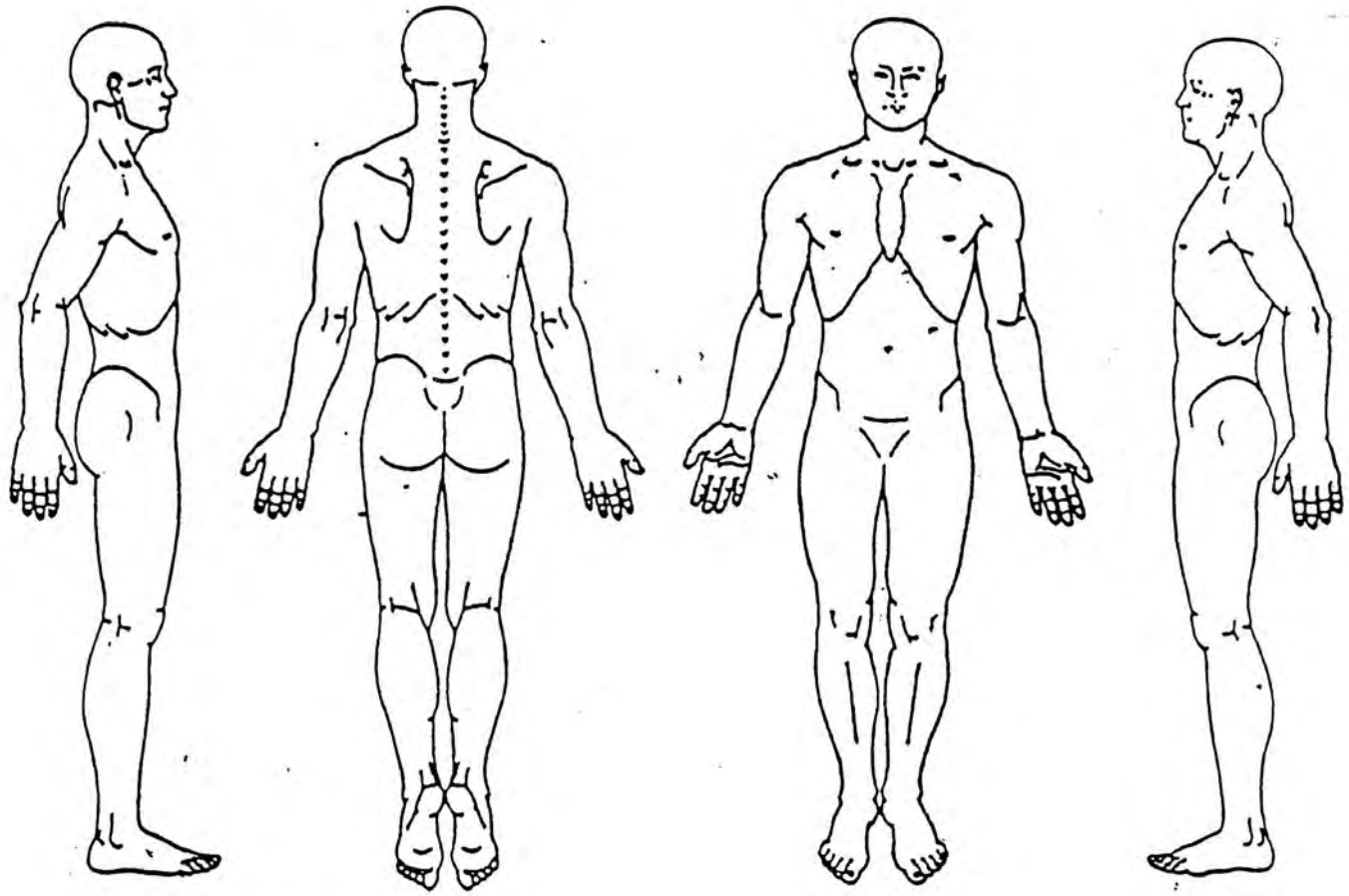
On a scale of 1-10 (1 being the least and 10 being the most)
___How committed are you to preventing Arthritis and maximizing your spine stability?

Name_____ Date_____

Please use the following key to accurately mark the areas in which you feel the described sensations. Use the appropriate symbols and include all affected areas.

Dull NNN Stabbing/Cutting /// /// /// Burning XXX

Numb = = = Tingling (Pins & Needles) : : : : : Cramping SSS



	0	1	2	3	4	5	6	7	8	9	10
Current pain intensity:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Average pain intensity:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Worst pain intensity:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you smoke? Yes ☐ No ☐ If yes, how many packs/day? < 1 ☐ 1 ☐ 2 ☐ 3 ☐ 3> ☐

Do you drink? Yes ☐ No ☐ If yes, amount: _____

Why did you come to our clinic and what are you expectations of us?

_____

I will be paying today by:

___CASH ___CHECK ___VISA ___MC ___DISCOVER ___OTHER_____

Patients Signature: _____ Date: ___/___/_____