

# PATIENT HISTORY

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Referred By: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_ Marital Status: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Names & Ages of Children \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Spouse's Name \_\_\_\_\_ Spouse's Birth date \_\_\_\_\_

Emergency Contact number \_\_\_\_\_ E-Mail Address \_\_\_\_\_

When did you last see a Chiropractor ? \_\_\_\_\_ Dr. \_\_\_\_\_

Is there any chance you are pregnant? ( ) Yes ( ) No

Have you experienced any recent unexplained weight loss? \_\_\_\_\_

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

Describe your major complaint: \_\_\_\_\_

How long ago did you notice this condition? \_\_\_\_\_

Please explain what activity or event first revealed your problem: \_\_\_\_\_

List drugs you now take (prescription and over the counter): \_\_\_\_\_

What of type doctors have you seen and or home remedies have you tried for **this** condition? **List the results of what was done:**

Have you had this similar condition before? Yes ( ) No ( ) When \_\_\_\_\_

**CONDITIONS: Check off any past or present conditions you may have had.**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Back curvature                                    | <input type="checkbox"/> Poor Posture                        | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Mental/emotional disorders                        | <input type="checkbox"/> Trouble concentrating               | <input type="checkbox"/> Loss of balance  |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Trouble sleeping                    | <input type="checkbox"/> Blurred or double vision R. or L.  |
| <input type="checkbox"/> Headaches/ Migraines                              | <input type="checkbox"/> Stroke                              | <input type="checkbox"/> Anemia   |
| <input type="checkbox"/> Convulsions/Epilepsy                              | <input type="checkbox"/> Excessive gas                       | <input type="checkbox"/> Menstrual problems/PMS   |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> High or low blood pressure          | <input type="checkbox"/> Eating disorder  |
| <input type="checkbox"/> Frequent colds/flu                                | <input type="checkbox"/> Learning disability                 | <input type="checkbox"/> Sinus problems   |
| <input type="checkbox"/> Depressed   | <input type="checkbox"/> Bedwetting                          | <input type="checkbox"/> Pregnant (now)   |
| <input type="checkbox"/> Irritable   | <input type="checkbox"/> Neck pain or stiff R or L           | <input type="checkbox"/> Upper back pain or stiffness R. or L.  |
| <input type="checkbox"/> Excess sweating                                   | <input type="checkbox"/> Heart problems                      | <input type="checkbox"/> Low back pain or stiffness R. or L.  |
| <input type="checkbox"/> Light bothers eyes                                | <input type="checkbox"/> Hepatitis/AIDS/HIV                  | <input type="checkbox"/> Syphilis   |
| <input type="checkbox"/> Heartburn   | <input type="checkbox"/> Diarrhea/constipation               | <input type="checkbox"/> Digestive problems   |
| <input type="checkbox"/> Ulcers  | <input type="checkbox"/> Chest pain                          | <input type="checkbox"/> Colon trouble  |
| <input type="checkbox"/> Light headed upon arising                         | <input type="checkbox"/> Prostate problems                   | <input type="checkbox"/> Numbness, tingling in arms/fingers R or L  |
| <input type="checkbox"/> Ear infections                                    | <input type="checkbox"/> Dizziness                           | <input type="checkbox"/> Leg pain in the buttock/thigh/calf R or L  |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Mid back pain or stiffness R. or L. | <input type="checkbox"/> Ringing in ears R. or L  |
| <input type="checkbox"/> Numbness, tingling in buttocks/thigh/feet R. or L |  | <input type="checkbox"/> Difficulty in excessive (Standing, walking, sitting, riding, bending, lifting, twisting, household duties) |

**PLEASE COMPLETE NEXT FORM**

