# CONFIDENTIAL PATIENT HEALTH HISTORY

Today's Date: _____ Patient #: _____

**PATIENT DEMOGRAPHICS**

Name: _____ Birth Date: ____-____-____ Age: ____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Cell Phone: _____

Marital Status: ☐ Single ☐ Married Spouse's Name: _____

Work Phone: _____ Number of Children & Ages: _____

Employer: _____ Occupation: _____

Name & Number of Emergency Contact: _____ Relationship: _____

Whom may we thank for referring you to this office? _____

Are you pregnant? ☐ N ☐ Y Due Date: _____

If **job related**, have you reported this accident to your employer? ☐ **N** ☐ **Y,** _____ **Date of injury**

If related to a **car accident**, have you reported this injury to the insurance? ☐ **N** ☐ **Y,** _____ **Date occurred**

**FINANCIAL INFORMATION** – ***Please allow our staff to photocopy your insurance card.***

☐ Insurance ☐ Self-Pay (cash) ☐ Personal/Auto ☐ Other (please explain) _____

**Primary Insurance**

Name: _____

Relation to Insured: Self/Spouse/Parent/Child/Other

*Other than self:*
Insured's Name: _____

Date of Birth: _____ ☐ M ☐ F

Social Security #: _____

**Secondary Insurance**

Name: _____

Relation to Insured: Self/Spouse/Parent/Child/Other

*Other than self:*
Insured's Name: _____

Date of Birth: _____ ☐ M ☐ F

Social Security #: _____

**HISTORY OF COMPLAINT**

Please identify the condition(s) that brought you to our office today:

First: _____ How Long? _____ Second: _____ How Long? _____

Third: _____ How Long? _____ Fourth: _____ How Long? _____

On a scale of **1** to **10** with 10 being the worst and **zero** being no pain, rate the above complaints by **circling:**

**First** complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
**Second** complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
**Third** complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
**Fourth** complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Describe how your *primary complaint* began. What caused it or what were you doing when you noticed the pain?**

_____

_____

_____

**Is the complaint/pain?** Dull/ Achy/ Burning/ Sharp/ Numb/ Stiff & Sore/ Stabbing/ Other_____

_____

**Does the complaint radiate/shoot to any areas of your body?** No / Yes ***If Yes, circle where below:***

*Head* – Base of Skull / Forehead / Temples R / L / Both *Leg* – Hip / Thigh-Knee/ Foot-Toes R / L / Both

*Arm* – Shoulder / Elbow/ Hands-fingers R / L / Both *Other Area*: _____

_____

**What makes your symptoms feel better?** Ice / Heat / Rest / Movement / Stretching / Medication / Other: _____

_____

**What makes your symptoms feel worse?** Sit / Stand / Lying / Walking / Overuse / Sleep / Other: _____

_____

**How frequent are the symptoms?** Constant / Comes & Goes -- *on & off during the day / on & off during the week*

_____

**Have you received any prior care for this condition?** MD / PT / Massage / Urgent Care / Acupuncture / Other:

_____

**Have you seen a Chiropractor before?** ☐ N ☐ Y If yes, who & when?_____

What were the results? ☐ Favorable ☐ Unfavorable → please explain:

_____

**Have you had any other injury(s) to your spine, minor or major? List even if it was over 20 years ago:**
car accidents / slips & falls / sports injuries / military / police / fire background / hospitalizations / etc.

_____

_____

_____

**How does this condition affect your daily activities?** *Can't workout or pick up kids or concentrate at work or sit through a movie...*

_____

_____

_____

**PAST MEDICAL HISTORY**

**Have you ever been diagnosed with any of the following conditions:** None ☐

Tumors ☐ Cancer ☐ Heart Attack ☐ Diabetes ☐ Autoimmune ☐ Rheumatoid Arthritis ☐ Fractures ☐

Osteoarthritis ☐ Cerebral-Vascular ☐ Any other medically diagnosed conditions? _____

_____

*Indicate if you have ever been diagnosed with any of the following: ***P*** for in the **Past**, ***C*** for **Currently***
**(Circle the one that applies - ie: Diarrhea/Constipation)**

__ Recent Weight Change
__ Fever
__ Fatigue
__ Sciatica L/R
__ Hip Pain L/R
__ Headaches/Migraines
__ Dizziness/ light-headed
__ Pain/Numb Arms-Legs
__ Tingling/Weak Arm-Leg
__ Weak muscles or Joints
__ Stiff / Swollen Joints

__ Sinus/Allergies
__ Ringing/Buzzing in Ears
__ Pain behind Eyes
__ Blurred Vision
__ Ear infections
__ Loss of Taste/Smell
__ Faint/Loss of Balance
__ Thyroid Problems
__ Depression
__ Stroke
__ Convulsions/Seizures

__ Difficulty Sleeping
__ Chest Pain
__ Shortness of Breath
__ Heart Palp/Murmur
__ Cold Sweats/Hot Flash
__ Asthma / Wheezing
__ Upper Resp. Infection
__ Heart Burn/Indigestion
__ Ulcers/Acid Reflux
__ Loss of Appetite
__ Memory Loss/ Confusion

__ Diarrhea / Constipation
__ Blood in Stool / Urine
__ Nausea / Vomiting
__ Abdominal Pain
__ Frequent Urination
__ Urinary Tract Infection
__Cramping/Irregular Periods
__ Difficulty Getting Pregnant
__ Impotence
__ Nervousness/Anxiety
__ Mood Swings/Irritable

**List any surgical operations and year they were performed:** *(type / year / right or left)*

_____

_____

**List any broken bones / fractures or dislocations you have had:** *(right or left / year)*

_____

_____

**List any medications you are taking:** *Did you bring a list? May we make a copy?* ☐ None

_____

**List any vitamins or supplements you are taking:** *Did you bring a list? May we make a copy?* ☐ None

_____

**FAMILY HISTORY** *Ie: Relationship: Maternal Grandmother*

☐ Heart Disease Relationship: _____
☐ Stroke Relationship: _____
☐ Cancer Relationship: _____
☐ Autoimmune Relationship: _____

Type of Cancer or Autoimmune: _____

Any other family history that might be relevant? _____

**SOCIAL HISTORY**

Do you smoke? ☐No ☐Yes _____packs/day
Do you drink coffee? ☐No ☐Yes _____cups/day
Do you wear Heel Lifts: ☐No ☐Yes
Do you drink alcohol? ☐No ☐Yes _____drinks/day
Do you exercise regularly? ☐No ☐Yes
Do you do recreational drugs? ☐No ☐Yes

**Is there anything else you would like the doctor to know?** _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services. I clearly understand and agree that all services rendered are ultimately my responsible for payment.

_____ _____ - _____ - _____
Patient or Guardian Signature Date Completed

_____ _____ - _____ - _____
Doctor's Signature Date Form Reviewed