# *PATIENT HISTORY*

In order to help us render the proper Chiropractic services to you, please answer the following questions, and fill in the blanks when indicated. All answers to our questions are for our records and are considered confidential. Thank you for your cooperation.

Patients Name ______________________________ Date __________________
Last First Initial

Residence Address ________________________________________________
Number Street City State Zip

Email ________________________ Home Phone _________________________

Business Phone _________________ Cell Phone ___________________________

Best time of day to contact ____________________ Occupation _______________

Employed by __________________ SS# ______________ DOB________________

Driver's License # _______________ Insurance Company ______________________

Marital status: Single ☐ Married ☐ Spinal health: Excellent ☐ Fair ☐ Poor ☐

On a scale of 1-10 **(10 highest)** what priority do you give your spine? 1 2 3 4 5 6 7 8 9 10

Name of MD ______________________ Former Chiropractor __________________

Whom may we thank for referring you? ___________________________________

Reason for visit ______________________________________________________

______________________________________________________________________

Have you ever had a head or neck injury? Describe ___________________________

______________________________________________________________________

Date of injury ______________ Surgeries ____________ Are you exercising? _______

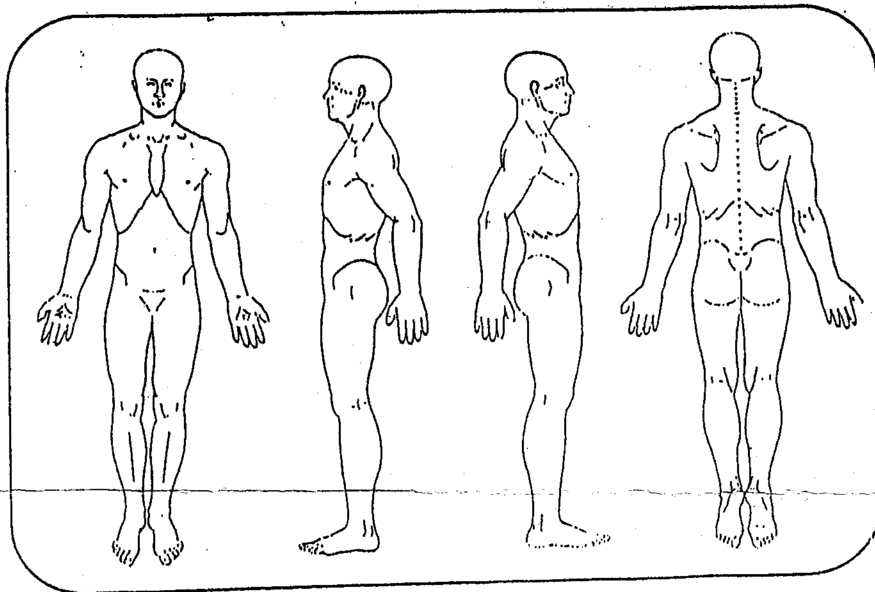
Describe exercises ____________________________________________________

Scale of 1-10 **(10 highest)** what number would you give your pain? 1 2 3 4 5 6 7 8 9 10

Patient's signature ____________________________________________________

**PLEASE COMPLETE OTHER SIDE: →→**

If you are in pain, please mark the exact location(s) in the box below.



MAJOR PROBLEMS:

___

___

___

causes:

___

___

___

___

___

similar episodes or treatment :

___

___

___

___

PRESENT SYMPTOMS:

HEAD

____ HEADACHE
____ BACK OF HEAD
____ FOREHEAD
____ TEMPLES
____ MIGRAINE
____ LIGHT-HEADEDNESS
____ FAINTING
____ LIGHTS BOTHER EYES
____ LOSS OF SMELL
____ DIZZINESS
____ HEARING PROBLEMS

NECK

____ PAIN IN NECK
____ STIFF NECK
____ GRATING SOUNDS IN NECK
____ GRINDING SOUNDS IN NECK
____ ARTHRITIS IN NECK

SHOULDERS

____ TENSION (R-L)
____ PAIN (R-L)
____ ARTHRITIS (R-L)
____ CAN'T RAISE ARM
____ ABOVE SHOULDER LEVEL
____ OVER HEAD

MID-BACK

____ PAIN BETWEEN SHOULDERS

ARMS AND HANDS

____ PAIN IN UPPER ARM (R-L)
____ PAIN IN FOREARM (R-L)
____ PAIN IN HANDS (R-L)
____ PAIN IN FINGERS (R-L)
____ PINS & NEEDLES (WHERE________)
____ HANDS COLD
____ SWOLLEN JOINTS IN FINGERS
____ ARTHRITIS IN FINGERS
____ LOSS OF GRIP STRENGTH

CHEST

____ CHEST PAIN
____ SHORTNESS OF BREATH
____ PAIN AROUND RIBS
____ ABODOMEN
____ NERVOUS STOMACH
____ NAUSEA
____ GAS
____ CONSTIPATION
____ DIARRHEA

MENSTRUAL CYCLE

____ CRAMPING
____ IRREGULARITY
____ DURATION
____ LIGHT
____ MODERATE
____ HEAVY
____ PREGNANCY

LOW BACK

____ PAIN
____ WORKING
____ LIFTING
____ STOOPING
____ STANDING
____ SITTING
____ BENDING
____ COUGHING
____ ARTHRITIS

HIPS, LEGS & FEET

____ PAIN IN BUTTOCKS (R-L)
____ PAIN IN HIP (R-L)
____ PAIN DOWN LEG (R-L)
____ PAIN IN KNEE (R-L)
____ NUMBNESS OF LEG (R-L)
____ NUMBNESS OF FEET (R-L)
____ NUMBNESS OF TOES (R-L)
____ FEET FEEL COLD (R-L)
____ SWOLLEN ANKLES (R-L)
____ SWOLLEN FEET (R-L)

GENERAL

____ NERVOUSNESS
____ IRRITABLE
____ DEPRESSED
____ FATIGUE/RUN DOWN
____ LOSS/INCREASE OF SLEEP
____ LOSS/GAIN WEIGHT