

## PERSONAL HISTORY

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

Social Security No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Sex: Female Male

City: \_\_\_\_\_

Check One:  Married  Single  Widowed

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Divorced  Separated

Home Phone: (\_\_\_\_\_) \_\_\_\_\_

No. of Children: \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Cellular Phone: (\_\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Business Employer: \_\_\_\_\_

Type of Work: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_

Phone No.: (\_\_\_\_\_) \_\_\_\_\_

Referred to this office by: \_\_\_\_\_

Who is responsible for your bill?:  Self  Spouse  Workman's Comp.  Medicaid  Medicare

Auto Insurance  Personal Health Insurance  Other: \_\_\_\_\_

**Are you a Medicare patient?**  YES  NO **Will you become a Medicare patient in the near future?**  YES  NO

## CURRENT HEALTH CONDITION

*This section provides information about the main reason that you are seeking care today. By providing the specific details, the doctor can thoroughly assess the nature of your condition and how to best approach it.*

What is your primary complaint? \_\_\_\_\_

When did this condition begin? (please be specific) Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

Do you know what brought this condition on? (i.e. accident, fall, etc.)  Yes  No

If no, what do you think is the cause? \_\_\_\_\_

How often do you experience the symptoms? (Circle one) Constant Frequent Intermittent Occasional Rarely

What makes the symptoms worse? (i.e. standing, sitting, heat, etc.) \_\_\_\_\_

What relieves the symptoms? (i.e. nothing, ice, heat, walking, sitting, etc.) \_\_\_\_\_

Does coughing or sneezing aggravate this condition?  Yes  No

Describe the pain (please circle one): Sharp Dull Ache Burn Throb Numb Other: \_\_\_\_\_

Does the pain radiate to another area or is it localized?  Localized  Radiates → where to? \_\_\_\_\_

Do you notice the pain more at a particular time of the day?  Morning  Afternoon  Evening  All the time

On a scale of 1-10, 10 being the worst, please rate your pain (circle one): 1 2 3 4 5 6 7 8 9 10

Other Doctors seen for this condition: Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

**Secondary Complaints**

Please list any other areas of complaint (i.e. neck, headaches, indigestion, etc.) and the dates each began:

Complaint: \_\_\_\_\_ Rate the Pain (1-10): \_\_\_\_\_ Approx. Date: \_\_\_\_\_

Complaint: \_\_\_\_\_ Rate the Pain (1-10): \_\_\_\_\_ Approx. Date: \_\_\_\_\_

Previous Chiropractic Care:  No  Yes Approximate date of last visit: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

***Additional Information you would like the doctor to know***

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**PAST HEALTH HISTORY**

**Surgeries/Operations:**  Appendectomy- Date: \_\_\_\_\_  Gall Bladder- Date: \_\_\_\_\_

Hernia- Date: \_\_\_\_\_  Tonsillectomy- Date: \_\_\_\_\_  Other: *(list below)*

Type: \_\_\_\_\_ Approximate date: \_\_\_\_\_ Doctor: \_\_\_\_\_

Type: \_\_\_\_\_ Approximate date: \_\_\_\_\_ Doctor: \_\_\_\_\_

Have you ever been hospitalized for any other reason?  No  Yes- Reason: \_\_\_\_\_

Please list all previous accidents or falls: Incident: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

Are you here because of a recent accident or fall?  No  Yes- Reason: \_\_\_\_\_ Date: \_\_\_\_\_

***If you are here because of a recent automobile accident or work related injury, please inform our staff so that additional forms may be completed and the terms of your care discussed in more detail. This will serve as a protection for both parties.***

Please list all previous fractures and dislocations:

Fracture/Dislocation: \_\_\_\_\_ Date: \_\_\_\_\_

Fracture/Dislocation: \_\_\_\_\_ Date: \_\_\_\_\_

Please list all medications and supplements you take. *(If additional, please inform the doctor upon consultation):*

Type: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Dosage: \_\_\_\_\_

Type: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Dosage: \_\_\_\_\_

Type: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Dosage: \_\_\_\_\_