

# PATIENT HISTORY

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_  
 Name: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ # of Children: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Drivers License #: \_\_\_\_\_  
 Policy holder Name: \_\_\_\_\_ Policy holder DOB and SSN: \_\_\_\_\_

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

MAJOR COMPLAINT \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

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

Have you lost work days: Yes ( ) No ( ) How many? \_\_\_\_\_

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

Was the injury related to: work accident ( ) auto accident ( )

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

Why did you see this Chiropractor? \_\_\_\_\_ Were you helped? \_\_\_\_\_

What spinal maintenance programs were you given to follow to maximize the future stability of your spine? \_\_\_\_\_

Did you follow it? \_\_\_\_\_ If not, why? \_\_\_\_\_

Why are you changing Chiropractors? \_\_\_\_\_

**PAST (O) OR PRESENT (X) CONDITIONS:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Fractured Bones<br><input type="checkbox"/> Auto Accidents<br>(a) <input type="checkbox"/> 0-1 years ago<br>(b) <input type="checkbox"/> 1-5 years ago<br>(c) <input type="checkbox"/> More than 5 years ago<br><input type="checkbox"/> Other Accidents/Falls<br><input type="checkbox"/> Knocked Unconscious<br><input type="checkbox"/> Back Curvature<br><input type="checkbox"/> Mental or Emotional Disorders<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Swollen or Painful Joints<br><input type="checkbox"/> Convulsions/Epilepsy<br><input type="checkbox"/> Skin Problems<br><input type="checkbox"/> Itching<br><input type="checkbox"/> Bruise Easily<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Frequent Colds/Flu<br><input type="checkbox"/> Nervous<br><input type="checkbox"/> Tension<br><input type="checkbox"/> Depressed<br><input type="checkbox"/> Irritable<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Excess Sweating<br><input type="checkbox"/> Tremors<br><input type="checkbox"/> Light Bothers Eyes<br><input type="checkbox"/> Allergy<br><input type="checkbox"/> Sinus Problems<br><input type="checkbox"/> Light Headed upon Rising<br><input type="checkbox"/> Under stress<br><input type="checkbox"/> Crave Sweets or Salt<br><input type="checkbox"/> Eating disorders<br><input type="checkbox"/> Trouble Sleeping<br><input type="checkbox"/> Trouble concentrating<br><input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Learning Disability<br><input type="checkbox"/> Mistake sidedness (R from L)<br><input type="checkbox"/> Stutter<br><input type="checkbox"/> Dyslexia<br><input type="checkbox"/> Mood Changes<br><input type="checkbox"/> Lose Temper easily<br><input type="checkbox"/> Headache<br><input type="checkbox"/> Neck pain or stiff R L<br><input type="checkbox"/> Numbness, tingling, or pain in arms, hands, fingers R L<br><input type="checkbox"/> Jaw pain or click (T.M.J.) R L<br><input type="checkbox"/> Head seems too heavy<br><input type="checkbox"/> Head & Shoulders feel tired<br><input type="checkbox"/> Difficulty in excessive (standing, walking, sitting, riding, bending, lifting, twisting, household duties)<br><input type="checkbox"/> Shoulder pain R L<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Ringing in ears R L<br><input type="checkbox"/> Hearing loss R L<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Loss of Balance<br><input type="checkbox"/> Blurred or double vision R L<br><input type="checkbox"/> Upper back pain or stiffness R L<br><input type="checkbox"/> Mid back pain or stiffness R L<br><input type="checkbox"/> Lower back pain or stiffness R L<br><input type="checkbox"/> Numbness, tingling or pain in buttocks, thighs, legs, feet, toes R L<br><input type="checkbox"/> Pain with cough, sneeze or strain at stools<br><input type="checkbox"/> Hip pain R L<br><input type="checkbox"/> Foot trouble R L<br><input type="checkbox"/> Chest pain<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Lung problems<br><input type="checkbox"/> Difficult Breathing | <input type="checkbox"/> Wheezing<br><input type="checkbox"/> Heart Problems<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> High or low blood pressure<br><input type="checkbox"/> Varicose Veins<br><input type="checkbox"/> Liver Trouble<br><input type="checkbox"/> Gall Bladder trouble<br><input type="checkbox"/> Digestive problems<br><input type="checkbox"/> Excessive Gas<br><input type="checkbox"/> Belching/bloating after meals<br><input type="checkbox"/> Heartburn<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Diarrhea/constipation<br><input type="checkbox"/> Colon Trouble<br><input type="checkbox"/> Hemorrhoids<br><input type="checkbox"/> Prostate problems<br><input type="checkbox"/> Impotence<br><input type="checkbox"/> Kidney trouble<br><input type="checkbox"/> Kidney stones<br><input type="checkbox"/> Frequent urination<br><input type="checkbox"/> Discharge<br><input type="checkbox"/> Menstrual problems/PMS<br><input type="checkbox"/> Menopausal problems<br><input type="checkbox"/> Breast lumps, soreness or discharge<br><input type="checkbox"/> Pregnant (now)<br><input type="checkbox"/> Bedwetting<br><input type="checkbox"/> Ear infections<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> Venereal Disease<br><input type="checkbox"/> AIDS/HIV |
|---|--|--|

WHAT ARE YOUR HEALTH GOALS? (What will motivate you to reach these goals?) \_\_\_\_\_

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

\_\_\_\_\_ Temporary Relief (Help the symptom but do not fix the cause of the problem)

\_\_\_\_\_ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US? \_\_\_\_\_

1. What are your favorite hobbies or activities to do now? \_\_\_\_\_
2. Are your current problems affecting these activities or hobbies? \_\_\_\_\_
3. What activities are you looking forward to doing in the future? \_\_\_\_\_
4. Who would you like to be doing these with? \_\_\_\_\_

On a scale of 1-10 (10 being the most and 1 being the least),

\_\_\_\_\_ How committed are you at being at your maximum health potential?

\_\_\_\_\_ How important is it for your family to be at their optimum health potential?

\_\_\_\_\_ How committed are you to preventing arthritis and maximizing your spinal stability?

What surgeries have you had? \_\_\_\_\_

List drugs you now take (prescription and non-prescription): \_\_\_\_\_

Name other doctors you have seen for this condition: what was done, and for how long?  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently wearing:           Heel lifts (    )   Arch Supports (    )

### **X-Ray Consent**

I do here by give my consent to allow the clinic of Family Care Chiropractic and its representatives to take x-rays as deemed appropriate by examining Doctor of Chiropractic. I also hereby declare that to my knowledge that I am NOT pregnant.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give my authority for these procedures to be performed. It is understood and agreed the amount paid to the facility for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Signed: \_\_\_\_\_

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

Printed: \_\_\_\_\_

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