

PERSONAL HISTORY

Dear Patient, welcome to our clinic, this form is designed to help us get to the cause of your current health problem as quickly as possible. The more detailed and accurate you are, the better care we can provide. Your overall health is just as important to us as your current major complaints. No symptom is insignificant. The more you tell us, the more we will be able to help you achieve your health goals.

Date: _____ Chart Number: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Birthdate: _____

Age: _____ Sex: M F Height: _____ Weight: _____

Business/Employer: _____ Type of work: _____

Check one: Married Single Divorced Separated

SS# _____ Spouse's Name: _____ No. of Children: _____

Referred to this office by: _____

Are you/have you been disabled from work? _____

Current Medications:

Tranquilizers Pain Killers / Muscle Relaxants Blood Pressure
 Insulin Aspirin / Similar Hormones Other

Specific drug or substance: _____

Natural Remedies: Vitamins / Minerals: _____

Herbs: _____

Homeopathics: _____

CURRENT HEALTH CONDITIONS

Please fill out one section for each major complaint, starting with the one you feel is most significant, indicate on drawings where your pain is located.

1. MAJOR COMPLAINT: _____ Date of onset: _____ Sudden Gradual

How bad is your pain or ache? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Describe your pain or complaint:

1. Dull Sharp Ache Stabbing
 Deep Superficial Spasm / Tension Numbness
 Tingling Burning Other

2. Radiation: Does the pain go to other parts of the body?
 Yes No Where? _____

3. Frequency: Occasional Intermittent Constant

4. Duration: How long does the pain last? _____

5. What makes the pain worse?

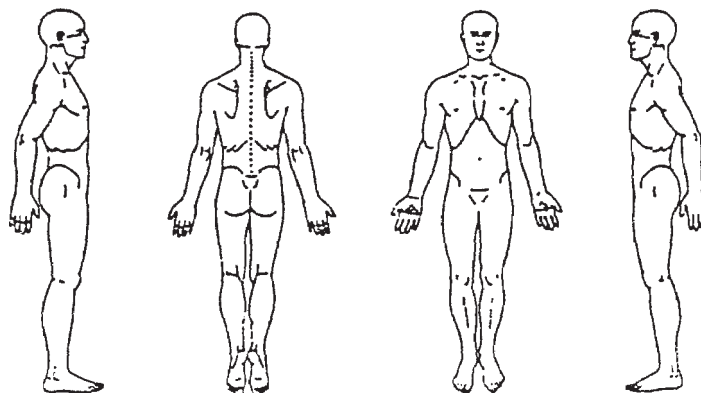
Standing Sitting Bending Twisting
 Walking Lifting Sleeping Heat
 Cold Stooping Sex Other

6. What makes the pain better?

Sitting Standing Rest Heat
 Cold Aspirin / Medication Other

7. Other problems related to your main complaint: _____

8. What treatment have you received for this condition? _____



2. MAJOR COMPLAINT: _____ Date of onset: _____ Sudden Gradual

How bad is your pain or ache? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Describe your pain or complaint:

1. Dull Sharp Ache Stabbing
 Deep Superficial Spasm / Tension Numbness
 Tingling Burning Other

2. Radiation: Does the pain go to other parts of the body?
 Yes No Where? _____

3. Frequency: Occasional Intermittent Constant

4. Duration: How long does the pain last? _____

5. What makes the pain worse?

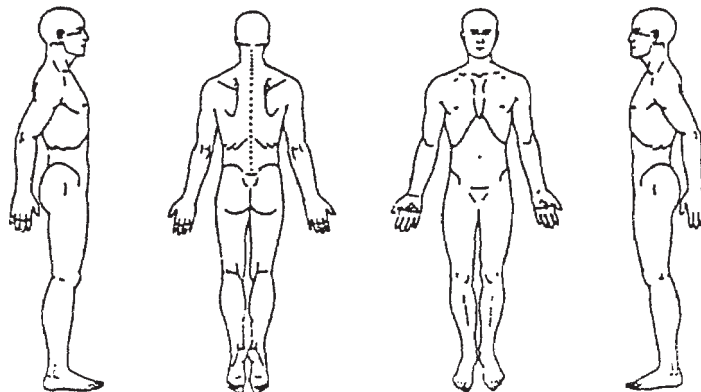
Standing Sitting Bending Twisting
 Walking Lifting Sleeping Heat
 Cold Stooping Sex Other

6. What makes the pain better?

Sitting Standing Rest Heat
 Cold Aspirin / Medication Other

7. Other problems related to your main complaint: _____

8. What treatment have you received for this condition? _____



1. MINOR COMPLAINT: _____ Date of onset: _____ Sudden Gradual
 How bad is your pain or ache? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10
 No Pain Unbearable Pain

Describe your pain or complaint:

1. Dull Sharp Ache Stabbing
 Deep Superficial Spasm / Tension Numbness
 Tingling Burning Other

2. Radiation: Does the pain go to other parts of the body?

Yes No Where? _____

3. Frequency: Occasional Intermittent Constant

4. Duration: How long does the pain last? _____

5. What makes the pain worse?

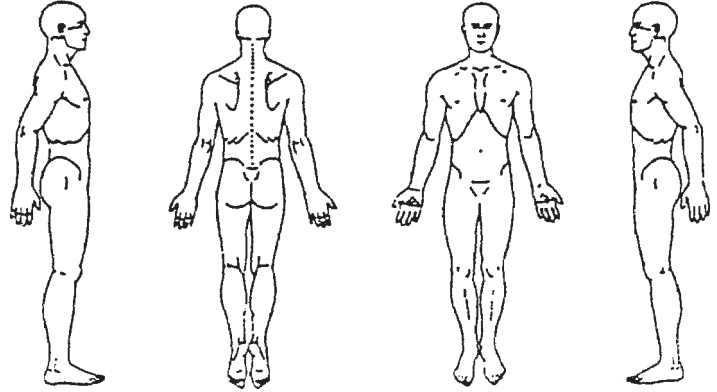
- Standing Sitting Bending Twisting
 Walking Lifting Sleeping Heat
 Cold Stooping Sex Other

6. What makes the pain better?

- Sitting Standing Rest Heat
 Cold Aspirin / Medication Other

7. Other problems related to your main complaint: _____

8. What treatment have you received for this condition? _____



PAST HEALTH HISTORY

List all surgery with dates: _____

Any major or minor accidents (include "fender benders") and falls (gymnastics, horse, etc.): _____

Hospitalization (other than above): _____

Previous Chiropractic care: Yes No Dr.'s Name _____

Date of last visit: _____ Condition treated: _____ X-rays taken: _____

Last medical physical: _____ Most recent blood work: _____

Check any of the following conditions you have experienced other than your current major complaints:

1. MUSCULO-SKELETAL

	Past	Present	Mild	Moderate	Severe		Past	Present	Mild	Moderate	Severe
Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg pain / numbness / weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain between shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arm pain / numbness / weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot / Ankle problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain / stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult chewing / clicking jaw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Knee problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Hip problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. NERVOUS SYSTEM

Nervousness:

Do you consider yourself to be a "nervous type" in general? _____

Are you feeling nervous about something specific? _____

Forgetfulness:

Are you forgetting recent events? _____

Events from the distant past? _____

Do you forget other things? _____

Is memory worse with stress? _____

Numbness:

Where? _____

When did it start? _____

Frequency: Occasional Intermittent Constant

Dizziness: Past Present

Fainting: Past Present

Stress: Past Present Rate your level of stress on a scale of 1 to 10:

Please circle a number: 0 1 2 3 4 5 6 7 8 9 10
 No Pain Unbearable Pain

Depression: Past Present

If present, how long have you been depressed? _____

Have you ever taken prescribed medications for depression? Yes No

If yes, list medications _____

Are you getting professional counseling? Yes No Is there a family history of depression? Yes No

Is your current depression related to a specific situation? Yes No

Is your depression: Mild Moderate Severe

Cold or Tingling Extremities: Hands Feet Both

Date of onset: _____

Frequency: Occasional Intermittent Constant

3. GENERAL

- Fatigue: Past Present If present: Mild Moderate Severe Daily? Yes No
Is there a pattern? Describe: _____
- Headaches: Past Present If present, how frequent: Daily Weekly Monthly
Degree: Mild Moderate Severe Location of pain: _____
Is there a pattern? Describe: _____
How long has this pattern of headaches existed (days / weeks / months / years)? _____
Do you have any idea what causes or triggers your headaches? _____
Females only: Is there a relationship to your menstrual cycle? Yes No
- Allergies: Airborne Food Unknown
List known allergies: _____
How often? Daily / weekly / monthly, or if "seasonal" which seasons? _____
What kind of symptoms do you have with your allergies? _____
- Bleeding Tendencies: Where? _____ How often? _____
How severely? _____
How long have you had this problem? _____
- Loss of Sleep: Past Present If present, how frequently does this occur? _____
When did this pattern begin? _____
Do you have difficulty falling asleep or staying asleep? (check one or both) Yes No
What factors do you think cause or influence this condition? _____
- Skin Conditions: Past Present
Describe condition: _____
List past treatments and effectiveness: _____
- Fever:
When was your last fever? _____
How often do you get fevers? _____
How severe do they get? _____

4. GENITRO URINARY

- Bladder Infections:
When was your last one? _____ How often do you have one? (per year) _____
What factors do you think cause or influence this condition? _____
- Frequent Urination: (other than associated with bladder infections) How frequent? (times per day) _____
- Discolored Urine: Past Present If present, when did it begin? _____
- Incontinence: Past Present If present when did it begin? _____
- Dribbling: Past Present If present when did it begin? _____
- Blood in Urine: Past Present If present when did it begin? _____

5. CARDIOVASCULAR/RESPIRATORY

- Chest Pain: Past Present If present, when does it occur? _____
Treatment? _____
- Shortness of Breath: Past Present When does it occur? _____
- Heart Disease: Past Present
Describe: _____
- Ankle Swelling: Past Present If present is it constant? _____
- Blood Pressure Problems: Past Present High Low
Medication: _____
- Lung Problems / Congestion:
Describe: _____
- Stroke: When? _____
Residual problems? _____
- Chronic Cough: When did it start? _____ Are you a smoker? _____
- Irregular Heartbeat / Murmurs (circle one or both): _____
Describe: _____
Have you seen a medical doctor for this? _____
- Varicose Veins: Past Present
When did they start? _____ Are they painful? _____
What aggravates them? _____

6. EYES, EARS, NOSE AND THROAT

- Vision Problems: Past Present Specify problem: When did it begin? _____
List treatments: _____
- Earaches / Infections: Past Present When was the last episode? _____
How often do they occur? _____ Severity of the problem? _____
List treatment: _____
- Dental History:
List present problems: _____
List past problems: _____
Have you ever had braces / orthodontics? _____ Did they pull teeth as part of your orthodontic treatment? Yes No
If yes, how many? _____ Who is your present dentist? _____
- Hearing Difficulty: Past Present
Please describe: _____
When did it begin? _____ List any treatment and its effectiveness: _____
- Sore Throat: Past Present
If present, when did it begin? _____ How severe is it? _____
What do you think caused or influenced this condition? _____
List any treatment and its effectiveness: _____
- Nose and Sinus Problems: Past Present
Describe: _____
When did it begin? _____
How severe is it? _____
What do you think causes or influences this condition? _____
List any treatment and its effectiveness: _____
- Noises in Ear: Past Present
Describe: _____
When did this begin? _____
What do you think causes or influences this condition? _____

7. GASTRO-INTESTINAL

- Poor / Excessive Appetite (circle one or both): Past Present When did it start? _____
Do you feel you have an unhealthy relationship with food? Yes No Are you a compulsive eater? Yes No
Are you or have you ever been considered: Anorexic Bulimic
Do you feel over-concerned or obsessed with your weight and / or body image? Yes No
- Diarrhea: Past Present If present, frequency: Occasional Intermittent Constant
When did it start? _____
What do you think causes or influences it? _____
Is it related to: Specific foods Stress
- Gall Bladder Problems: Past Present If present, describe symptoms: _____
- Liver Problems: Past Present If present, describe symptoms: _____
- Heartburn: Frequency: Occasional Intermittent Constant
All foods? _____
Certain foods only? _____
Is there a time of day when it's worse? _____
- Excessive Thirst: Past Present When did it begin? _____
- Constipation: Past Present If present, when did it begin? _____
Is this a lifetime pattern? Yes No
What do you think causes or influences this condition? _____
Do you take any medications or natural substances to assist in bowel function? (list) _____
- Weight Change: As an adult, what has your weight range been? High: _____ Low: _____
- Black/Bloody Stool: Past Present When did it start? _____
- Ulcers: When? _____
Treatment? _____
- Nausea: Past Present If present, frequency: Occasional Intermittent Constant
Time of day _____ Certain foods? _____ Other factors? _____
- Hemorrhoids: Past Present Are they: Painful Bleeding
What factors affect it? _____
- Abdominal Cramps/Pain: Past Present If present, location: _____
When do they occur? Intensity: Mild Moderate Severe
- Hepatitis: Past Present When did it start? _____
- Vomiting: Past Present If present, when did it start? _____

Colitis: Past Present If present, when did it start? _____
What factors effect it? _____

Gas / Bloating After Meals: Certain foods? Past Present If present, all meals? Yes No

8. FEMALE PROBLEMS

Your age at first period: _____ How many days do you flow? _____

Most recent period began, date: _____ How many days from period to period? _____

Last PAP smear: _____ History of abnormal PAP? Yes No

If abnormal what class? _____

Treatment? _____

Contraception (present): _____

Past history of birth control pill use: How long? _____ Side effects? _____

Number of pregnancies: _____ Live births _____ Are you pregnant now? Yes No Unsure

Menstrual Cramping: Mild Moderate Severe

Do you get cramps every month? Yes No If not, how often? _____

Spotting

PMS (Pre-menstrual Syndrome): Yes No If yes: Mild Moderate Severe

How many days of symptoms before your period? _____

Check symptoms:

Breast tenderness Food cravings Irritability

Crying easily Bloating / Weight gain Suicidal

Other _____

Painful Intercourse: Past Present

Breast Lumps / Fibrocystic: Past Present

Vaginal Infections / Yeast: Past Present Frequency, how many times per year? _____

DES Mother

Sexual Dysfunction: Past Present Describe: _____

Ovarian, Vaginal, or Uterine Problems: Past Present

Infertility: Past Present Treatment: _____

9. MALE PROBLEMS

Prostate Problems: Past Present If present, describe symptoms: _____

When did this begin? _____

List any treatmnt and its effectiveness: _____

Incomplete Voiding of Urine: Past Present If present, describe symptoms: _____

When did this begin? _____

List any treatment and its effectiveness: _____

Pain during Urination: Past Present

If present, describe symptoms: _____

List any treatment and its effectiveness: _____ When did this begin? _____

Sexual Dysfunction: Past Present

If present, describe symptoms: _____

List any treatment and its effectiveness: _____ When did this begin? _____

10. DISEASE

Check any of the following diseases you have had:

- | | | | | |
|--|--------------------------------------|--|---|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Genital Warts |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Eczema | <input type="checkbox"/> German Measles / Rubella |

11. Have you been treated for any other condition not covered in the above questionnaire (describe)? _____

When? _____

12. SLEEP HABITS: Average hours per night: _____

13. BOWEL MOVEMENTS: Times per week: _____

14. DIET

Please describe your diet by indicating how many times per day / week / month you have the following:

Eggs	_____ times per _____	Alcohol	_____ times per _____
Milk products	_____ times per _____	Chocolate	_____ times per _____
Wheat products:		Other sweets	_____ times per _____
Pasta	_____ times per _____	Soft drinks	_____ times per _____
Bread	_____ times per _____	White flour products	_____ times per _____
Rolls / Muffins	_____ times per _____	Water	_____ times per _____
Red meat	_____ times per _____	Fried food	_____ times per _____
Chicken	_____ times per _____	Cigarettes	_____ times per _____
Fish	_____ times per _____	Grains	_____ times per _____
Fresh vegetables	_____ times per _____	Foods craved:	_____
Fresh fruit	_____ times per _____	Meals per day:	_____
Salad	_____ times per _____		
Coffee	_____ times per _____		
Tea (caffeinated)	_____ times per _____		

15. EXERCISE Type _____ Frequency _____ Times (day or week)
Type _____ Frequency _____ Times (day or week)
Type _____ Frequency _____ Times (day or week)

Patient's Signature X _____ Date _____