



**ADVANTAGE**  
CHIROPRACTIC

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_

**WHAT BROUGHT YOU INTO THE OFFICE**

If you have no symptoms or complaints and are here for wellness services, please check here \_\_\_\_\_.

CURRENT HEALTH CONDITION (why are you here today): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did this condition start? \_\_\_\_\_

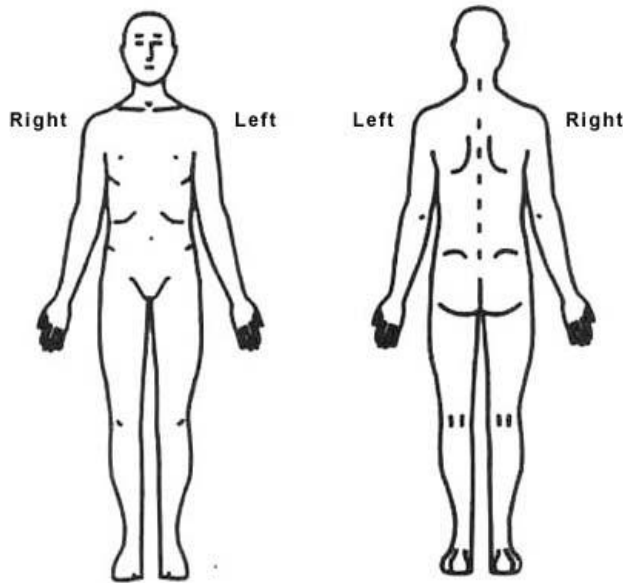
Has it ever occurred before? o Yes o No When? \_\_\_\_\_

Is the condition: o Auto Related o Work Related o No Injury o Other

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT:

Use the letters below to indicate the type and location of your sensations right now:

DA=Dull Ache SA=Sharp Ache B=Burning N=Numbness/Tingling P=Pins & needles  
S=Stabbing T=Throbbing



Patient Name \_\_\_\_\_

Patient #: \_\_\_\_\_

Since the problem(s) started, it is...  Getting Better  About the Same  Getting Worse

What makes the pain/problem worse?

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The pain interferes with:  Walking  Sitting  Hobbies  Socializing  Sleep  Work  
 Personal Care  Lifting  Reading  Concentration  Driving  Sex Life

What helps the pain/problem?

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Please list other practitioners you have seen for this issue.

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Are you currently taking any prescription medications?  Yes  No If yes, please mark or list

Allergy medications  Anti-depressants  Blood Pressure Medications  Insulin  Muscle Relaxers  Nerve Pills  Pain Killers  Other \_\_\_\_\_

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Are you wearing any of the following?  Heel Lifts  Innersoles  Arch Supports  Orthotics

Have you had recent blood work?  Yes  No If yes, when \_\_\_\_\_

### YOUR HEALTH BELIEFS

What tools have you used to try to reduce stress?

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What bad habits do you need to release?

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How do you currently support your health?

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

Patient #: \_\_\_\_\_

**Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.**

**REVIEW OF SYSTEMS-Please fill out all of the sections, even if "DENY".**

**Constitutional: I...o Deny any constitutional issue (s)**

- Chills
- Daytime Somnolence (Drowsiness)
- Fatigue
- Fever
- Night Sweats
- Weight gain
- Weight Loss

**Eyes/Vision: I...o Deny any Eyes/Vision issue (s)**

- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Eye Pain
- Field Cuts (visual field defect)
- Glaucoma
- Itching (around eyes)
- Photophobia
- Tearing
- Wears Glasses and/or Contact lenses

**Ears, Nose and Throat: I...o Deny any Ears, Nose and Throat Issue (s)**

- Bleeding
- Dental Implants
- Dentures
- Difficulty Swallowing
- Discharge
- Dizziness
- Ear Drainage
- Ear Infection (s)
- Ear Pain
- Fainting
- Headaches
- Head Injury (history of)
- Hearing Loss
- Hoarseness
- Loss of Smell
- Nasal Congestion
- Nose Bleeds (frequent)
- Post Nasal Drip
- Runny Nose
- Sinus Infections
- Snoring
- Sore Throats (frequent)
- Tinnitus
- TMJ Problems

**Respiration: I...o Deny any Respiratory Issue (s)**

- Asthma
- Cough
- Coughing up blood
- Shortness of breath
- Sputum Production
- Wheezing

**Cardiovascular: I...o Deny any Cardiovascular Issue (s)**

- Angina
- Claudication (leg pain/achiness)
- Heart Murmur
- Heart Problems
- Orthopnea (difficulty breathing while lying down)
- Palpitations
- Swelling of Legs
- Paroxysmal Nocturnal Dyspnea (waking @ night with shortness of breath)
- Ulcers
- Varicose Veins
- Shortness of breath with exertion or exercise

**Gastrointestinal: I...o Deny any Gastrointestinal Issue (s)**

- Abdominal pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice
- Nausea
- Rectal Bleeding
- Abnormal Stool
- Vomiting Blood
- Vomiting

**Female: I...o Deny any Female Issue (s)**

- Birth Control Therapy
- Breast Lumps/Pain
- Burning Urination
- Cramps
- Frequent Urination
- Hormone Therapy
- Irregular Menstruation
- Urine Retention
- Vaginal Bleeding/Discharge

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

Patient #: \_\_\_\_\_

REVIEW OF SYSTEMS (continued)

**Male: I... Deny any Male Issue (s)**

- Burning Urination
- Erectile Dysfunction
- Frequent Urination
- Hesitancy/Dribbling
- Prostate Problems
- Urine Retention

**Endocrine: I... Deny any Endocrine Issue (s)**

- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Frequent Urination
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

**Skin: I... Deny any Skin Issue (s)**

- Changes in Nail Texture
- Changes in Skin Color
- Hair Growth
- Hair Loss
- Hives
- Itching
- Paresthesia
- Rash
- History of Skin Disorders
- Skin Lesions/Ulcers
- Varicosities

**Nervous System: I... Deny any Nervous System Issue (s)**

- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors
- Unsteadiness of Gait

**Psychologic: I... Deny any Psychologic Issue (s)**

- Anhedonia (inability to enjoy life)
- Anxiety
- Appetite Change (s)
- Behavioral Change (s)
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Insomnia
- Memory Loss
- Mood Change (s)

**Allergy: I... Deny any Allergy Issue (s)**

- Anaphylaxis (history of)
- Food Intolerance
- Itching
- Nasal Congestion
- Sneezing

**Hematology: I... Deny any Hematologic Issue (s)**

- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion (s)
- Bruises Easily
- Fatigue
- Lymph Node Swelling

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**SOCIAL HISTORY**

Alcohol:  Never  Social Consumption only  Beer  Liquor  Wine; amt \_\_\_\_\_  day  week  month

Diet (please mark all that apply):  Low Fat  High Fiber  High Protein  High Salt  Low Calorie  
 Low Carb  Low Fiber  Low Salt  Low Sugar  Paleo  
 Pre-packaged meal plan (WeightWatchers, Nutrisystem, etc.)

Drugs:  Deny any illegal drug use  Deny use of IV drugs  Have not used drugs since \_\_\_\_\_

Have used drugs for \_\_\_\_\_

Tobacco:  Deny any tobacco use  Live with a smoker  Quit smoking, when \_\_\_\_\_

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

Patient #: \_\_\_\_\_

**PATIENT HEALTH HISTORY-**

Please fill out carefully as these problems can affect your overall course of care.

**Childhood Illness: I...o Deny any Childhood Illness (es)**

- ADD
- Allergies/Hayfever
- Asthma
- Atopic Dermatitis (Eczema)
- Bedwetting
- Cerebral Palsy
- Chicken Pox
- Depression
- Diabetes
- Ear Infection
- Fetal Drug Exposure
- Food Allergies
- Headaches
- Hepatitis
- HIV
- Measles
- Seizure disorder
- Mumps
- Scoliosis
- Rash
- Sickle Cell Anemia
- Spina Bifida
- Other: \_\_\_\_\_

**Adult Illnesses: I...o Deny any Adult Illness (es)**

- Alzheimers
- Anemia
- Arthritis
- Asthma
- Cancer
- Chicken Pox
- Crohn's/Colitis
- CRPS (RSD)
- CVA (stroke)
- Cystic Kidney disease
- Depression
- Diabetes (insulin)
- Diabetes (non)
- Ear infections
- Emphysema
- Eye Problems
- Fibromyalgia
- Heart Disease
- Hepatitis
- HIV
- Hypertension
- Influenzal pneumonia
- Liver Disease
- Lung disease
- Lupus (discoid)
- Lupus (systemic)
- Multiple sclerosis
- Parkinson's disease
- Pleurisy
- Pneumonia
- Psychiatric problems
- Scoliosis
- Seizure disorder
- Shingles
- STD's (unspecified)
- Suicide attempt (s)
- Thyroid Problems
- Vertigo

**Surgeries: I...o Deny any Surgery (ies)**

Please list what and when:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Injuries: I...o Deny any Injury (ies)**

Please list what and when:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Non-drug Allergies: I...o Deny any Non-Drug Allergy (ies)**

- Animals
- Dairy
- Eggs
- Food Colorings
- Mold
- Pollen
- Wheat (Gluten)
- Other (please be specific): \_\_\_\_\_

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

Patient #: \_\_\_\_\_

**FAMILY HISTORY**

**Condition (please be specific)**

Father     Alive     Deceased     No significant disease     Has/Had: \_\_\_\_\_

Mother     Alive     Deceased     No significant disease     Has/Had: \_\_\_\_\_

Paternal Grandfather     Alive     Deceased     No significant disease     Has/Had: \_\_\_\_\_

Paternal Grandmother     Alive     Deceased     No significant disease     Has/Had: \_\_\_\_\_

Maternal Grandfather     Alive     Deceased     No significant disease     Has/Had: \_\_\_\_\_

Maternal Grandmother     Alive     Deceased     No significant disease     Has/Had: \_\_\_\_\_

Son (s)             Alive     Deceased     No significant disease     Has/Had: \_\_\_\_\_

Daughter (s)     Alive     Deceased     No significant disease     Has/Had: \_\_\_\_\_

Brother (s)     Alive     Deceased     No significant disease     Has/Had: \_\_\_\_\_

Sister (s)         Alive     Deceased     No significant disease     Has/Had: \_\_\_\_\_

Is there anything else you would like us to know, which we have not covered?

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