**National Pike Chiropractic**

**565 National Pike West, Brownsville, PA 15417**

**www.nationalpikechiropractic.com**

Name: ________________________________________ Sex M F Date:_________________________

Address______________________________________City______________________State________Zip_________________

Home Phone_______________________Cell Phone______________________Contact Preference_______________________

Email:_____________________________________________________Date of Birth___________________Age__________

Referred by_________________________________________________Social Security #________________________________

Occupation________________________________________Employer_________________________________________________

**1. Primary reasons for seeking chiropractic care:**

Primary reason:___________________________________________________________________________________________

Secondary reason:_________________________________________________________________________________________

Other factors contributing to the primary and secondary reasons:___________________________________________________

**2. Chief Complaint:**__________________________________________________________________________________

Location of Complaint:_____________________________________________________________________________________

Complaint began when and how?:___________________________________________________________________________

Please circle the quality of the complaint/pain:

dull aching sharp shooting burning throbbing deep nagging other___________

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?___________________________________

Do you have any numbness or tingling in your body? Where?_________________________________________________________

Grade intensity/severity (no complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain/complaint imaginable)

How frequent is the complaint present, how long does it last?___________________________________________________________

Does anything aggravate the complaint?______________________________________________________________________

Does anything make the complaint better?____________________________________________________________________

**3. Previous interventions, medications, treatments, surgery, or care you've sought for your complaint:**_______________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

**4. Were the symptoms caused from an automobile accident or a work injury? Yes No (Please circle)**

**5. Have you ever had chiropractic care before? Yes No (Please circle)**

**If Yes: Date of last treatment?** ____________________

**6. Name of medical doctor:**________________________________________ **Date of last visit:**________________________

**May we send information regarding your care at our office to your medical doctor? Yes No (Please circle)**

## Past Health History:

**Review of Systems: Have you experiences any of the following? Mark with a checkmark for yes**

1. **General: ___Weight Loss or Weight Gain ___Fatigue ____Fever ___Weakness ___Trouble Sleeping**
   **If yes, please explain:________________________________________________________________________**
2. **Skin: ___Rash ___Itching ___Lumps ___Color Changes ___Changes in hair or nails**
   **If yes, please explain:________________________________________________________________________**
3. **Head: ___headaches ___vertigo ___head injury ___lightheadedness**
   **Eyes: ___blurred vision ___double vision ___blind spots ___glaucoma ___cataracts**
   **Ears: ___hearing loss ___ringing ___earache ___discharge**
   **Nose: ___nose bleeding ___discharge ___stuffiness ___sinus pain**
   **Mouth: ___bleeding gums ___dry mouth ___dentures**
   **Throat: ___goiter ___lumps ___sore throats ___hoarseness**
   **If yes, please explain:________________________________________________________________________**
   ______________________________________________________________________________________
4. **Heart: ___High Blood Pressure ___High Cholesterol ___Chest Pain ___Edema (Swelling)**
   **If yes, please explain:________________________________________________________________________**
5. **Respiratory: ___Cough ___Painful Breathing ___Blood in Mucus ___Wheezing**
   **If yes, please explain:________________________________________________________________________**
6. **Allergies: ___Foods ___Medications ___Other**
   **If yes, please explain:________________________________________________________________________**
7. **Neurologic: ___Seizures ___Weakness ___Numbness/Tingling ___Tremors ___Memory Loss**
   **If yes, please explain:________________________________________________________________________**
8. **Genitourinary: ___Bladder Urgency/Frequency ___Incontinence ___Blood in Urine ___Kidney Stones**
   **If yes, please explain:________________________________________________________________________**
9. **Gastrointestinal: ___Recent changes in bowel habits ___Abdominal pain ___Loss of appetite ___Nausea**

**Previous injury or trauma: (Auto accidents, work injuries, slips, falls, sports injuries, etc.)________________**

_______________________________________________________________________________________________

**Have you ever broken any bones?**

**If yes, which?_______________________________________________ When?__________________________________________**

| Medication | Reason for taking |
|---|---|
| ______________________________________ | ______________________________ |
| ______________________________________ | ______________________________ |
| ______________________________________ | ______________________________ |

| Nutritional Supplements | Reason for taking |
|---|---|
| ______________________________________ | ______________________________ |
| ______________________________________ | ______________________________ |
| ______________________________________ | ______________________________ |

***Do you have a pacemaker? Yes No (Please circle)**

**Surgeries:**

**Date** **Type of Surgery**

_____________________________________________ _____________________________

_____________________________________________ _____________________________

_____________________________________________ _____________________________

***Females?pregnancies and outcomes:**

**Pregnancies/Date of Delivery** **Outcome**

_____________________________________________ _____________________________

_____________________________________________ _____________________________

_____________________________________________ _____________________________

**What was the date of the beginning of your last menstrual period?___________________________________**

**Is there a possibility that you may be pregnant? Yes No (Please circle)**

## Family Health History: (Parents, Grandparents, Siblings)

**Associated health problems of relatives: Please describe which family member**

**Cancer:**_____________________________ **Heart Disease:**_____________________________

**Diabetes:**_____________________________ **High Blood Pressure:**_____________________________

**Stroke:**_____________________________ **Arthritis:**_____________________________

**Deaths in immediate family:**

**Cause of parents or siblings death** **Age at death**

_____________________________________________ ____________________

_____________________________________________ ____________________

_____________________________________________ ____________________

## Social and Occupational History:

**A. Level of Education:**

**___High School ___Some College ___College Graduate ___Post Graduate Studies**

**B. Job description:**_____________________________________________________________

**C. Work Schedule:**_____________________________________________________________

**D. Recreational activities:**_____________________________________________________________

**Is the condition you are consulting us for affecting these activities or hobbies? Yes No (Please circle)**

**E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**_____________________________

_____________________________________________________________________________

**I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statues.**

**Patient Signature (Parent/Guardian if minor)**_____________________________ **Date**_______________

**Doctor's Signature** _____________________________ **Date**_______________