Patient History Form

Name: ________________________________

Cardiovascular __No

	Present	Past	No
Poor Circulation			
High BP			
Aortic Aneurism			
Heart Disease			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

Genitourinary __No

	Present	Past	No
Kidney disease			
Lower side pain			
Burning urination			
Blood in urine			
Kidney stone			

Hematologic/Lymphatic: __No

	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fever			
Chills/Sweats			

Psychiatric: __No

	Present	Past	No
Depression			
Anxiety			
Unusual Stress			

Constitutional:
__No

	Present	Past	No
Weight Loss/Gain			
Energy level			
Difficulty Sleeping			

Respiratory: __No

	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Ears/Nose/Throat: __No

	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gum			

Eyes: __No

	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Integumentary: __No

	Present	Past	No
Skin Lesions			
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

Endocrine: __No

	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			

Allergic/Immunologic: __No

	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy shots			
Cortisone use			

Gastrointestinal: __No

	Present	Past	No
Gallbladder			
Bowel problems			
Constipation			
Liver problems			
Ulcers			
Diarrhea			
Nausea/ Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal: __No

	Present	Past	No
Gout			
Arthritis			
Joint stiffness			
Muscle weakness			
Osteoporosis			
Broken Bones			
Joint replaced			

Neurological: __No

	Present	Past	No
Babinski			
Stroke			
Seizures			
Head Injury			
Brain aneurysm			
Numbness			
Severe Headaches			
Pinched nerves			
Parkinson's			
Carpal Tunnel			
Spinning/ Balance			

Other:____

Surgeries:

__Appendectomy __Cardiovascular procedure __Disc Procedure __Hysterectomy
__Joint Replacement __Laminectomies __Radical prostatectomy __Transurethral prostate surgery

Patient History Form

Allergies:

__Eggs	__Fish & Shellfish	__Milk or Lactose	__Peanut
__Soy	__Sulfites	__Wheat/ Gluten	Other____________________

Social History:

__Caffeine used occasionally	__Stress occasionally	__Chew tobacco occasionally	__Exercise often
__Caffeine used often	__Stress often	__Chew tobacco often	__Exercise occasionally
__Drink Alcohol Occasionally	__Smoke >1 pack per day	__Wear seat belt Never	__Exercise not at all
__Drink Alcohol often	__Smoke 1 pack or less	__Wear seat belt Always	__Wear seat belt usually

Family History

__Arthritis (parent)	__Arthritis (sibling)	__Cancer (parent)	__Cancer (sibling)
__Cholesterol (parent)	__Cholesterol (sibling)	__Diabetes (parent)	__Diabetes (sibling)
__Heart problem (parent)	__Heart problem (sibling)	__High BP (parent)	__High BP (sibling)
__Psychiatric (parent)	__Psychiatric (sibling)	__ Stroke (parent)	__ Stroke (sibling)
__Thyroid (parent)	__Thyroid (sibling)	Other ____	

Substance Use:

__Alcohol (past)	__Alcohol (present)	__Amphetamines (past)	__Amphetamines (present)
__Barbiturates (past)	__Barbiturates (present)	__Cocaine (past)	__Cocaine (present)
__Crystal Meth (past)	__Crystal Meth (present)	__Heroine (past)	__Heroine (present)
__Marijuana (past)	__Marijuana (present)		

Male Children :

__Under 6 years	__Under 10 years	__Under 19 years

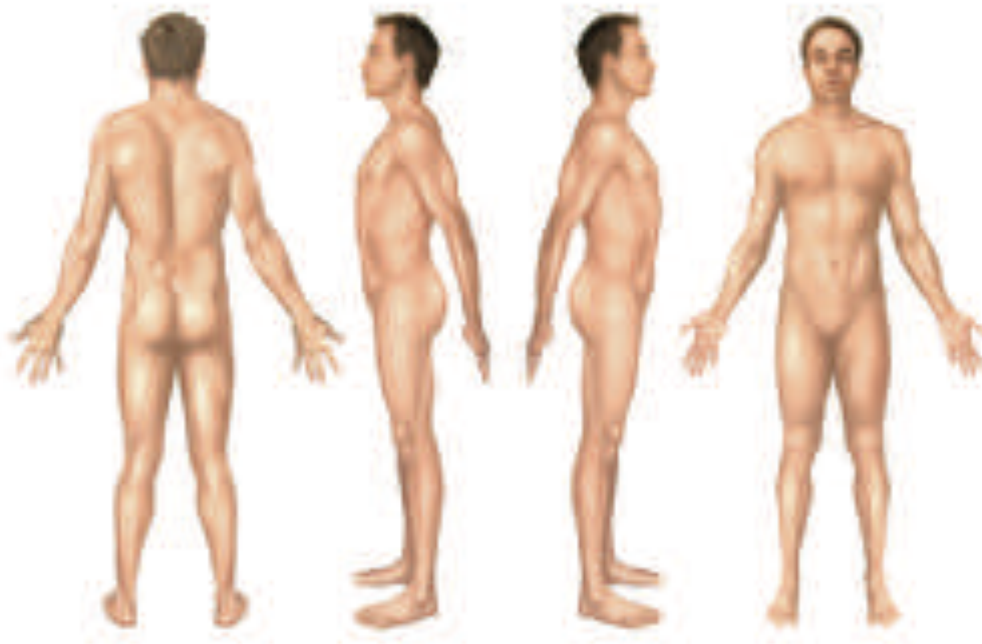
Female Children:

__Under 6 years	__Under 10 years	__Under 19 years

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

= Numbness X = Burning / = Stabbing 0 = Pins & Needles + = Dull Ache

Patient History Form



Describe your symptoms: ____

____

When did you symptoms start? Month ________________ Day ________________ Year________________

How did your symptoms begin? ____

____

How often do you experience your symptoms?

__Constantly (76-100% of the day) __Frequently (51-75% of the day) __Occasionally (26-50% of the day) __Intermittently (0-25% of the day)

What describes the nature of your symptoms?

__ Sharp __ Dull ache __ Numb __ Shooting
__ Burning __ Tingling __ Stabbing

How are your symptoms changing?

__ Getting better __ Not Changing __ Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0=None to 10=Unbearable)

__ 0 None __ 1 __ 2 __ 3
__ 4 __ 5 __ 6 __ 7
__ 8 __ 9 __ 10 Unbearable

During the past 4 weeks, how much pain interfered with your normal work (including work outside the home and housework)

__ Not at all __ A little bit __ Moderately __Quite a bit
__ Extremely

In general, would you say your overall health right now is…

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__ Excellent __ Very good __ Good __ Fair
__ Poor

Who have you seen for your symptoms:
__ No one __ Other Chiropractor __ Medical Doctor __ Physical Therapist
__ Other ____

What treatment did you receive for your symptoms?
__ Adjustments __ Physical Therapy __ Medication __ Surgery
__ Other ____

When did you receive this treatment?
__ In the last month __ 2-3 months ago __ 3-6 months ago __ 6 months to 1 year ago
__ 1-2 years ago __ 2-5 years __ 5-10 years

What tests have you had for your symptoms?
__ X-rays __ MRI __ CT scan __ Other ___________________________

Have you had similar symptoms in the past?
__ Yes __ No

If you have seen treatment in the past for the same or similar symptoms, who did you see?
__This office __ Other chiropractor __ Medical Doctor __ Physical Therapist
__Other ____