CHIROPRACTIC PATIENT HISTORY

So that we may better understand your unique condition, please complete the following information with regard to your current complaint.

Name:_____ **Date:** ____/____/____

Location:

What is your Primary Complaint? _____

What Caused the Onset? _____

When did it Start? _____/_____/_____

Does the Complaint Radiate or Travel? If so, Where? _____

Timing and Duration:

- ✓ Since the onset of your complaint how has it been changing? __ Getting Better __ Not Changing __ Getting Worse
- ✓ How often do you experience the complaint?
  __ Constantly (100%) __ Frequently (75%) __ Occasionally (50%) __ Intermittently (25%)
- ✓ When does it feel worse? __ No Change __ Morning __ As Day Progresses __ Afternoon __ Evening __ During the night
- ✓ When does it feel better? __ No Change __ Morning __ As Day Progresses __ Afternoon __ Evening __ During the night
- ✓ How much has the complaint interfered with your normal work? (including both work and outside the home and housework)
  __ Not at all __ A little bit __ Moderately __ Quite a bit __ Extremely
- ✓ How much would you say this complaint has affected your social activities?
  __ All the time __ Most of the time __ Some of the time __ A little of the time __ None of the time

Severity:

Use the key below to rate the severity of your pain.

0 = No Pain 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate 6 = Moderate to Severe

7 = Mildly Severe 8 = Severe 9 = Very Severe 10 = Excruciating a

Please Circle where you rate your pain: 1 2 3 4 5 6 7 8 9 10

Quality:

How would you describe the sensation of your complaint? (Circle all that apply)

Sharp Pain Shooting Numbness Tingling Dull Ache

Burning Throbbing Other _____

Modifying Factors:

What makes your complaint feel worse? (Circle all that apply)

Coughing / Sneezing Standing Lifting Exercising Bending Twisting Pushing / Pulling

Sitting Walking Driving Climbing Other: _____

Alleviating Factors:

What makes your complaint feel better? (Circle all that apply)

Rest / Sleep Stretching Lifting Exercising Bending Twisting Pain Medication Ice Heat

Shower Walking Other: _____

Previous Treatment:

Who have you seen for this condition?

___ Medical Doctor ___ Physical Therapist ___ Chiropractor ___ Other: _____

Have you had Chiropractic care in the past? ___ Yes ___ No If so, When? ___/___/___

Are you seeing anyone else for other problems or health conditions? (Circle one) Yes / No

*Please list the problem/s, date problem/s began, and provider/s treating you for the condition/s: _____

_____

Risk Factors:

Do you have a pace maker? ___ Yes ___ No Are you pregnant? ___ Yes ___ No ___ Maybe

Do you have any metal implants or devices? ___ Yes ___ No

Patient / Guardian Signature: _____ *Date:* ____/____/____ Dr: _____

PAST AND GENERAL HISTORY

To help us better understand your unique condition please complete the information below related to your past and general history.

Past History: Please Make Below With an "X"

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
x		*Example*	x	x	*Example*		x	*Example*
		Angina / Chest Pain			HIV			Seizures
		Arthritis			Hypertension			Sleeping Problems
		Asthma			Irritability			Soreness
		Back Pain			Joint Stiffness			Speaking Problems
		Balance Problems			Joint Swelling			Spinal Curvature
		Broken Bones			Joint Tenderness			Stiffness
		Cancer			Loss of Sleep			Stroke / TIA
		Chills			Lumps			Tingling
		Concentration Loss			Masses			Thyroid Problems
		Diabetes I / II			Memory Loss			Tremors
		Dizziness			Muscle Cramps			Vertigo
		Fatigue			Muscle Pain			Weakness
		Fainting			Nervousness			Other Please List:
		Fever			Night Sweats			
		Headaches			Numbness			
		Heat Problems			Paralysis			

Medication and Surgical History:

Are you currently taking any medications? (Please include regularly used over the counter medications, vitamins, herbs and minerals.) You may continue the medication information on the back if additional room is required.

Medication Name	Dosage and Frequency	Start Date of Medication

Do you have any allergies? (Circle all that apply): Food / Environment / Medication

Allergy	Reaction

***Please list any prior surgeries, major injuries or hospitalizations you may have had:** _____

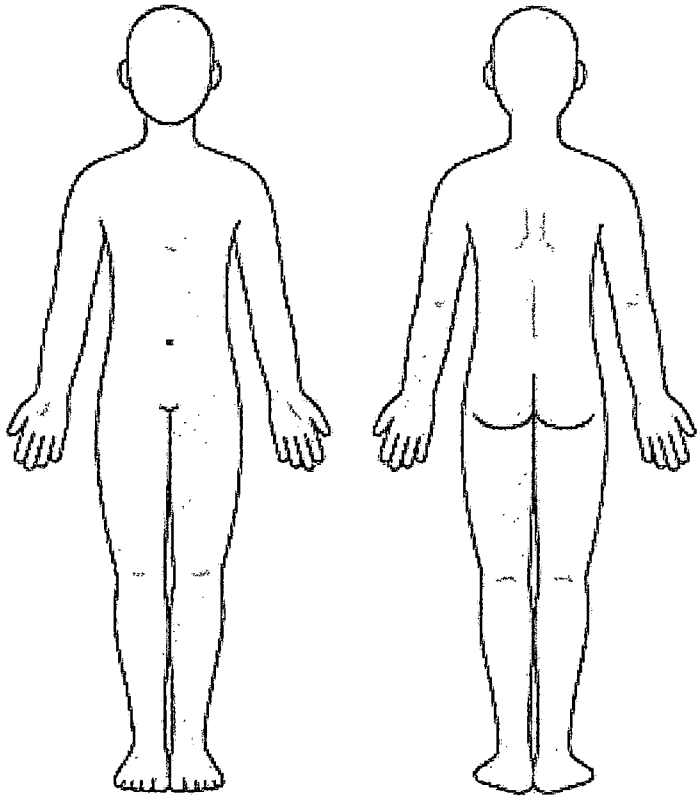
_____

☐ **I choose to decline receipt of my clinical summary after every visit** (*These summaries are often blank as a result of the nature and frequency of chiropractic care.*)

Patient / Guardian Signature: _____ *Date:* ____ / ____ / ____ Dr. _____

On the diagram below please mark with an x any area you are experiencing pain or discomfort!

Right Left Left Right



Front Back

How long can you perform each of the activities below before pain increases?

Walking? _____ Minutes Sitting? _____ Minutes Standing? _____ Minutes

Driving? _____ Minutes Exercising? _____ Minutes Sleeping? _____ Minutes

Please circle any of the following activities that are affected by pain.

Standing from a seated position Getting out of bed going up and down stairs

Cleaning Ironing Pet Care Gardening Laundry

Meal Prep/Cleanup Shopping Vacuuming

How far can you walk with no or minimal pain? __ 0-50ft __ 50-200 ft __500+ft __ ½ Mile+

Patient Signature_____ Date_____