



PATIENT HISTORY FORM

Patient: PLEASE PRINT

First Name M.I. Last
How did you hear about us?
Gender: M F Birthdate Age:
Are you: Single Married Divorced Widowed Separated
Home Address Apt #
City State Zip
Home Phone Pager/Cell Phone
Work Phone Ext.
E-mail Address
Occupation

Symptoms

Primary Complaint

When did it start?
Is this problem caused by an accident, injury, or fall? YES NO
Type of Injury: Auto Work Home Other
Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain)
(please circle a number) 1 2 3 4 5 6 7 8 9 10
Is this condition getting progressively worse? Yes No
Is the pain constant? Yes No
Activities or movements that are difficult to perform:
Sitting Standing Walking Bending Lying Down Dressing Bathing Squatting Reaching
Kneeling Lifting Driving Other
What treatment have you already received for this condition? Medications Physical Therapy Surgery
Chiropractic None Other
Time of day pain is worst

Secondary Complaint

When did it start?
Is this problem caused by an accident, injury, or fall? YES NO
Type of Injury: Auto Work Home Other
Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain)
(please circle a number) 1 2 3 4 5 6 7 8 9 10
Is this condition getting progressively worse? Yes No
Is the pain constant? Yes No
Activities or movements that are difficult to perform:
Sitting Standing Walking Bending Lying Down Dressing Bathing Squatting Reaching
Kneeling Lifting Driving Other
What treatment have you already received for this condition? Medications Physical Therapy Surgery
Chiropractic None Other
Time of day pain is worst



Other Complaints _____

Other Symptoms

- Headaches Pins & Needles in Legs Trouble Sleeping
- Neck Pain Pins & Needles in Arms Awaken from pain
- Upper Back Pain Numbness in Fingers Diarrhea / Constipation
- Mid Back Pain Numbness in Toes Low Back Pain
- Difficulty Breathing Hip Pain Fatigue Stomach Upset
- Leg Pain Depression Loss of Balance Shoulder Pain
- Ears Ringing / Buzzing Loss of Memory Chest Pain
- Light Bothers Eyes Irritability Dizziness Nervousness

Daily Habits

- Exercise: None Moderate Daily Heavy
- Work Habits: Sitting Standing Light labor Heavy labor
- Sleep Position: Side Stomach Back
- Do You Smoke? Yes No Packs/ Day _____
- Do You Drink Alcohol? Yes No Drinks/ Week _____
- Coffee/ Caffeine Drinks? Yes No Cups/ Day _____
- Do You Have High Stress? Yes No Reason _____

What Vitamins/Nutritional Supplements do you take?

What Medications are you taking? _____

Health History

Injuries/Surgeries you have had Description and Date:

- Falls _____
- Head Injuries _____
- Broken Bones _____
- Dislocations _____
- Surgeries _____
- Auto Accidents _____
- Hospitalizations _____
- Allergies _____
- Family History (related to your complaint) _____
- Are you Pregnant? Yes No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature _____

Date _____