CONFIDENTIAL PERSONAL HISTORY

PATIENT INFORMATION

Date_______________________

Name____

Street Address/Apt. # ____

Town/State/ZipCode____

Phone: (H)___________________(B)____________________(C)_______________

Email____

Age_____________Birth date____________________SS#____________________

Sex: ☐ M ☐ F Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Occupation________________________Employer___________________________

Referred By: ☐ Medical Doctor ☐ Insurance Co. ☐ Internet ☐ Other______________

Primary Care Physician____

In case of emergency, contact (Name & Phone) _________________________________

PATIENT CONDITION

Reason for visit____

Date of onset________________Causes (if known)______________________________

Are your symptoms getting worse? YES / NO

Frequency of symptoms: Constant / Daily / Intermittent

What improves your symptoms?____

What worsens your symptoms?____

Doctors seen for this condition_________________________Date(s)________________

Their diagnosis___________________________Their treatment_____________________

Results of treatment____

Tests for this condition X-ray MRI EMG Other__________________________

(Consultation Notes)

Name_______________________________________Date________________

HEALTH HISTORY

Previous chiropractic care: YES / NO
For what conditions?________________________Date last treated____________

(Please record all history of trauma)

	Description / Injuries	Date(s)
Car Accidents		
Sports injuries		
Other Traumas		
Hospitalizations		
Surgeries		

Medications / Nutritional Supplements	Taking For

Are you pregnant? YES / NO Due date_____________

PERSONAL HABITS:

☐ Coffee/Caffeine Cups/Day_________
☐ Alcohol Drinks/Week_______
☐ Smoking Packs/Day________ # of years_________
☐ Exercise Days/Week________ Type______________________
☐ Sleep Hrs/Night__________ Quality: Good / Poor

Name____Date________________

Please check any condition or symptom you now have or have had in the past.

Past	Present	GENERAL
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Sweats
☐	☐	Cancer
☐	☐	Diabetes
☐	☐	Significant infections
☐	☐	Alcoholism/Substance abuse
		ALLERGIES
☐	☐	Environment____________
☐	☐	Foods_________________
☐	☐	Drugs_________________
		NEUROLOGIC
☐	☐	Headache
☐	☐	Seizure/Epilepsy
☐	☐	Dizziness/Vertigo
☐	☐	Multiple Sclerosis
☐	☐	Polio
☐	☐	Muscle weakness
☐	☐	Numbness
☐	☐	Pinched Nerve
☐	☐	Bowel/bladder dysfunction
☐	☐	Other_____________
		RESPIRATORY
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Sleep Apnea
☐	☐	Shortness of breath

Past	Present	CARDIOVASCULAR
☐	☐	Heart Disease
☐	☐	Stroke
☐	☐	High/Low Blood Pressure
☐	☐	Abnormal EKG tests
☐	☐	Poor circulation
☐	☐	Varicose veins
☐	☐	Other__________________
		MUSCULOSKELETAL
☐	☐	Osteoporosis
☐	☐	Osteoarthritis
☐	☐	Rheumatoid arthritis
☐	☐	Bursitis
☐	☐	Tendonitis
☐	☐	Neck Pain
☐	☐	Midback Pain
☐	☐	Low Back Pain
☐	☐	Scoliosis
☐	☐	Herniated disc
☐	☐	Spinal stenosis
☐	☐	Arm Pain
☐	☐	Shoulder/Elbow/Wrist/Hand Pain
☐	☐	Leg Pain
☐	☐	Hip/Knee/Ankle/Foot Pain
☐	☐	Gout
☐	☐	Lyme Disease
☐	☐	Other__________________

☐ ☐ Other____________

Name____ Date__________________

Please check any condition or symptom you now have or have had in the past.

Past	Present	**SKIN**
☐	☐	Itching
☐	☐	Rashes
☐	☐	Psoriasis
☐	☐	Eczema
☐	☐	Other____________

Past	Present	**GASTROINTESTINAL**
☐	☐	Heartburn/Reflux
☐	☐	Nausea/vomiting
☐	☐	Hepatitis
☐	☐	Irritable bowel syndrome
☐	☐	Constipation
☐	☐	Reoccurring diarrhea
☐	☐	Other__________________

Past	Present	**EYES,EARS,NOSE,THROAT**
☐	☐	Change in vision
☐	☐	Eye pain
☐	☐	Glaucoma
☐	☐	Deafness/loss of hearing
☐	☐	Tinnitus/ringing in ears
☐	☐	Nose bleeds
☐	☐	Sinus problems
☐	☐	Jaw pain / TMJ
☐	☐	Thyroid disease
☐	☐	Difficulty swallowing
☐	☐	Other__________________

Past	Present	**GENITOURINARY**
☐	☐	Frequent urination
☐	☐	Painful urination
☐	☐	Blood in urine/change in color
☐	☐	Urinary tract infection
☐	☐	Other____________

Do you have any other significant health conditions not listed above?

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FAMILY HEALTH HISTORY

(please list any known health problems)

Relation	Health Conditions (Age diagnosed)
>Mother	
>Father	
>	
>	
>	