

# Patient History

Acct #: \_\_\_\_\_  
Date: \_\_\_\_\_  
Time: \_\_\_\_\_  
DI: \_\_\_\_\_  
DR: \_\_\_\_\_

Dear Patient: This form is confidential. We need this information to help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Please be as neat and accurate as possible while completing this form. PLEASE PRINT.

## | PERSONAL INFORMATION |

Name: \_\_\_\_\_ Marital Status: M S W D Sex: M F  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Drivers License #: \_\_\_\_\_ State: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer's Name: \_\_\_\_\_  
Business Phone: ( ) \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_  
Spouse's Business Phone: ( ) \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_  
Spouse's Birthdate: \_\_\_\_\_ Spouse's Social Security #: \_\_\_\_\_  
In Case of Emergency Notify: \_\_\_\_\_  
Name, Address, Phone # & Relationship of nearest relative (not living with you): \_\_\_\_\_  
Who referred you to our office? (full name): \_\_\_\_\_

## | INSURANCE INFO |

1st Insurance Company: \_\_\_\_\_  
2nd Insurance Company: \_\_\_\_\_  
Group Membership #: \_\_\_\_\_ ID/Policy #: \_\_\_\_\_  
Type of Insurance:  Group  Private  Auto  Personal Injury  Workers' Compensation  Attorney  Medicare  
Name of Insured if different from above: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

## | PRESENT HISTORY |

List all your current complaints:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Date & time of illness / injury: \_\_\_\_\_ Sudden   
Gradual

How did accident occur?  Auto Collision  On the job  Other \_\_\_\_\_

Have you lost time off work due to this injury?  Yes  No Dates: \_\_\_\_\_

Does this condition interfere with your normal daily routine?  Yes  No If yes, explain: \_\_\_\_\_

Name of primary care physician: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

**| PRESENT HISTORY CONTINUED |**

Name any other doctors seen for this problem: \_\_\_\_\_

List diagnosis(es) and types of treatment(s) given: \_\_\_\_\_

Did this previous treatment help your condition?  Yes  No  Temporarily

Have you had similar accidents or injuries before?  Yes  No If yes, explain: \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year?  Yes  No If yes, explain: \_\_\_\_\_

Patient History of Cancer: (type) \_\_\_\_\_ Family History of Cancer: (type) \_\_\_\_\_

Medications taken presently: \_\_\_\_\_

Have you ever been to a chiropractor before?  Yes  No Name of Doctor: \_\_\_\_\_

Place an "X" next to the items you presently, or have previously, suffered from:

**HEAD & NECK**

- \_\_\_ Headaches: Frequency \_\_\_ / Week
- \_\_\_ Head Injury: Location: \_\_\_\_\_
- \_\_\_ Light-headed
- \_\_\_ Jaw Pain
- \_\_\_ Depression / Anxiety

**CIRCULATORY PROBLEMS**

- \_\_\_ Anemia
- \_\_\_ Varicose Veins
- \_\_\_ Chest Pain
- \_\_\_ High Blood Pressure
- \_\_\_ Heart Disease
- \_\_\_ Cholesterol

**RESPIRATORY SYSTEM**

- \_\_\_ Asthma
- \_\_\_ Persistent Cough
- \_\_\_ Pain When Breathing
- \_\_\_ Difficulty Breathing

**DIGESTIVE COMPLAINTS**

- \_\_\_ Abnormal Pain
- \_\_\_ Gas / Bloating
- \_\_\_ Constipation / Diarrhea
- \_\_\_ Heartburn
- \_\_\_ Nausea
- \_\_\_ Excessive Weight Gain
- \_\_\_ Excessive Weight Loss
- \_\_\_ Ulcers

**NERVOUS-MUSCULAR-SKELETAL SYSTEM**

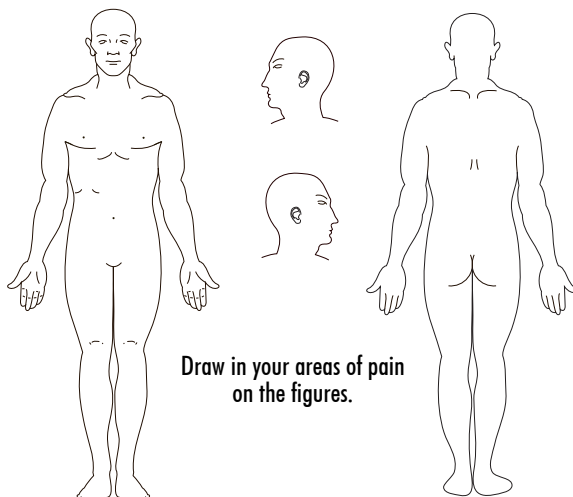
- \_\_\_ Neck Problems
- \_\_\_ Pain Between Shoulders
- \_\_\_ Shoulder-Elbow-Hand Problems: Where: \_\_\_\_\_
- \_\_\_ Low Back Problems
- \_\_\_ Hip-Knee-Foot Problems: Where: \_\_\_\_\_
- \_\_\_ Muscle Stiffness
- \_\_\_ Muscle Soreness
- \_\_\_ Muscle Spasms
- \_\_\_ Numbness: Where: \_\_\_\_\_
- \_\_\_ Tingling: Where: \_\_\_\_\_
- \_\_\_ Pain in Arms / Legs

**(F) FAMILY HISTORY (P) PATIENT HISTORY**

- |                             |                     |
|-----------------------------|---------------------|
| ___ Cold Sores              | ___ Frequent Colds  |
| ___ Rheumatic Fever         | ___ Stroke          |
| ___ Diabetes                | ___ Heart Condition |
| ___ Food Allergies          | ___ Arthritis       |
| ___ Environmental Allergies |                     |

**FEMALES ONLY**

- Are you pregnant?  No  Yes: Months: \_\_\_\_\_
- Date of last period: \_\_\_\_\_
- Date of last OB/GYN appointment: \_\_\_\_\_
- Number of children: \_\_\_\_\_
- Number of miscarriages: \_\_\_\_\_
- Menstrual Cramping: \_\_\_\_\_
- Menstrual Irregularity: \_\_\_\_\_ Increased Bleeding: \_\_\_\_\_
- Hot Flashes: \_\_\_\_\_



I understand that I am responsible for payment of all services at the time rendered. If this is not acceptable, other arrangements must be made with the office in advance.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(if patient is a minor, name of parent, guardian, etc..)