# Patient History (Please Print)

Date:_____

Name: _____ Email: _____Cell Phone: _____

Address: _____City: _____ Zip: _____ Hm Phone: _____

Birth Date: _____ ☐ Male ☐ Female Spouse's Name: _____

Children #_____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed Driver's License # _____

Occupation _____Social Security# : _____ Wk Phone: _____

How were you referred to the Office? _____

Have you ever been under chiropractic care before? _____ If yes, when? _____

**List your chief complaint in order of severity: Check all those that describe your condition:**

**Complaint 1:** _____ For how long? _____

What originally caused this problem? _____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling ☐Burning

☐Other: _____ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Constant (100%) ☐ Frequent (50% - 90%) ☐ Intermittent (25% - 50%) ☐ Occasional (1% - 25%)

**Complaint 2:** _____ For how long? _____

What originally caused this problem? _____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling ☐Burning

☐Other: _____ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Constant (100%) ☐ Frequent (50% - 90%) ☐ Intermittent (25% - 50%) ☐ Occasional (1% - 25%)

**Complaint 3:** _____ For how long? _____

What originally caused this problem? _____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling ☐Burning

☐Other: _____ ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Constant (100%) ☐ Frequent (50% - 90%) ☐ Intermittent (25% - 50%) ☐ Occasional (1% - 25%)

Does your condition interfere with your:

| | | | | |
|---|---|---|---|---|
| Work | ☐ NO | ☐ MILD | ☐ MODERATE | ☐ SEVERE |
| Sleep | ☐ NO | ☐ MILD | ☐ MODERATE | ☐ SEVERE |
| Daily Routine | ☐ NO | ☐ MILD | ☐ MODERATE | ☐ SEVERE |
| Recreation | ☐ NO | ☐ MILD | ☐ MODERATE | ☐ SEVERE |

Goals for Care :

_____

_____

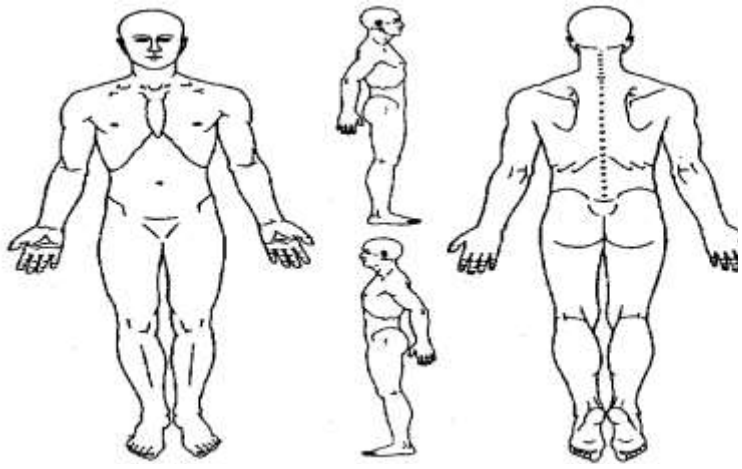
_____

_____

List other doctors consulted for this condition:

1. _____ Address: _____
2. _____ Address: _____

Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels.
Include all affected areas



**Family History ( please list all known conditions/illnesses that may apply):**

Mother: _____
Father: _____
Grandparents: _____
Siblings: _____

Other known familial condition:

_____
_____
_____
_____

Is there anything else you think we should know about or that you would like to discuss: ( Explain): _____
_____
_____

Are you Pregnant: ☐ Yes ☐ No Due Date: _____

**CONCERNS:** We've found that these are the common concerns people like you have. We want to make sure you are comfortable before we start care. Add any others that are relevant and **circle your top 3.**

| | | |
|---|---|---|
| Is it going to hurt? | Is it expensive? | What do I do if chiropractic does not work? |
| Do I have to come forever? | Are the X-rays dangerous? | I don't want to be cracked |
| Is it safe for children? | Can this be fixed? | What if insurance does not cover chiropractic? |
| Is it addictive? | _____ | _____ |

**STRENGTHS:** Strong habits are key to health: It helps us take care of you if we have an idea of how you take care of your body. Ad any others that are relevant **and circle you top 3.**

| | | |
|---|---|---|
| Stretch 3-5 times a week | Exercise 3-5 times a week | Drink ½ my body weight of ounces of water |
| Take supplements for health | Have a positive attitude | Drink or eat something green everyday |
| Sleep 6-8 hours a night | Do activities to minimize stress regularly | Get maintenance chiropractic 4-8 times a year |
| Non-smoker | _____ | _____ |

**GOALS:** We want to make sure you get lasting relief and enjoy maximum functional improvement. Add any others that are relevant **and circle you top 3.**

| | | |
|---|---|---|
| Sleep through the night | Continue working/get back to work | Play with kids/grandkids normally |
| Exercise again | Avoid future flare ups | Sit/Stand comfortably for an extended period |
| Get of pain medications | Have some moments of relief | Be ready for an upcoming event |
| Have a better attitude | _____ | _____ |

**Patient's Signature: _____ Date: _____**

**Notice:** Not all patients require x-rays to determine or verify a diagnosis, type and length of care. If your examination warrants x-ray analysis, the following office policy prevails: All first visit charges are to be paid when services are rendered. The fee paid for x-rays is for analysis only. The film itself is the property of this office and cannot be released.

**If you have insurance please give the front desk your card**