

## PERSONAL HISTORY

Date: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Name: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Email: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Carrier (i.e. AT&T, Verizon, etc.) \_\_\_\_\_

May we contact you by text message for things such as appointment reminders, scheduling changes, thank you messages, etc? (usage rates may apply) Yes \_\_\_\_\_ No \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F

Check One:  Married  Single  Widowed  Divorced  Separated

Children's Names: \_\_\_\_\_ Age: \_\_\_\_\_ Health Conditions?: \_\_\_\_\_

Business/Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone number of Emergency Contact: \_\_\_\_\_

Referred to this Office By: \_\_\_\_\_

Who is responsible for this bill?  Self  Spouse  Personal Health Insurance

Medicare  Auto Insurance  Other

**\*\*If this is a car accident (Personal Injury), please ask at the front desk for the appropriate forms.**

## CURRENT HEALTH CONDITION

Major Problem: \_\_\_\_\_

What caused this problem: \_\_\_\_\_

Doctors seen for this problem: \_\_\_\_\_

When did this problem begin: \_\_\_\_\_

If disabled from work, please give dates: \_\_\_\_\_

Is this problem Job-related? Yes \_\_\_\_\_ No \_\_\_\_\_ Auto-related? Yes \_\_\_\_\_ No \_\_\_\_\_

List all medications you now take:

Name of Medication	What condition are you taking this medication for?
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_____	_____
_____	_____
_____	_____

## PAST HEALTH HISTORY

List major surgeries/operations:

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Trauma (such as car accidents or significant falls):

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Broken bones: \_\_\_\_\_

Hospitalizations (other than above): \_\_\_\_\_

Previous chiropractic care?:  Yes  No

Name of Doctor: \_\_\_\_\_ Approximate date of last visit: \_\_\_\_\_

## PERSONAL HISTORY

### Radiology/Dates:

Previous X-rays Date: \_\_\_\_\_ Area \_\_\_\_\_ Why? \_\_\_\_\_

Previous CAT scans: Date: \_\_\_\_\_ Area \_\_\_\_\_ Why? \_\_\_\_\_

Previous MRI Date: \_\_\_\_\_ Area \_\_\_\_\_ Why? \_\_\_\_\_

**Habits:** Sleep (hours/night) \_\_\_\_\_ Alcohol (drinks/week) \_\_\_\_\_

Tobacco (packs/day) \_\_\_\_\_ Chew \_\_\_\_\_

Caffeine (Coffee/Tea/Soda) (Amount/day) \_\_\_\_\_ Exercise (times/week) \_\_\_\_\_

Hobbies \_\_\_\_\_

### Family Health History: (Please describe)

Father's Health: Poor/Fair/Good/Excellent, Current Health Conditions? \_\_\_\_\_

Mother's Health: Poor/Fair/Good/Excellent, Current Health Conditions? \_\_\_\_\_

Brother's/Sister's Health: Poor/Fair/Excellent/Good, Current Health Conditions? \_\_\_\_\_

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian (when applicable): \_\_\_\_\_

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan, and possibility of being accepted for care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Appendicitis    | <input type="checkbox"/> Malaria        | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Alcoholism         |
| <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Venereal Infection |
| <input type="checkbox"/> Diphtheria      | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Typhoid Fever   | <input type="checkbox"/> Anemia         | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy           |
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Measles        | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Mental Disorder    |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Lumbago            |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Small pox      | <input type="checkbox"/> Pleurisy      | <input type="checkbox"/> Eczema             |
| <input type="checkbox"/> HIV             |   |  |   |

**CHECK ANY OF THE FOLLOWING YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST 6 MONTHS:**

**Musculo-Skeletal Code**

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint pain/stiffness
- Walking Problems

**Nervous System Code**

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities

**General Code**

- Allergies
- Loss of Sleep
- Fever

**Gastro-Intestinal Code**

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Colitis
- Liver Trouble
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Difficulty Chewing/Clicking jaw
- Gas/Bloating after Meals
- Heartburn
- Black/bloody stools

**Genito-Urinary Code**

- Bladder Trouble.
- Painful/Excessive Urination
- Discolored Urine

**C-V-R Code**

- Chest pain
- Shortness of Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling

**EENT Code**

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffy Nose

**Male/Female Code**

- Menstrual Cramping
- Menstrual Irregularity
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Genital Herpes

**Are You Pregnant?**

Yes  No  Not Sure

