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?

____

____

____

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:

___ Appendicitis
___ Scarlet Fever
___ Diptheria
___ Typhoid Fever
___ Pneumonia
___ Rheumatic Fever
___ Polio
___ HIV
___ Malaria
___ Tuberculosis
___ Whooping Cough
___ Anemia
___ Measles
___ Mumps
___ Small pox
___ Chicken Pox
___ Diabetes
___ Cancer
___ Heart Disease
___ Goiter
___ Influenza
___ Pleurisy
___ Alcoholism
___ Veneral Infection
___ Arthritis
___ Epilepsy
___ Mental Disorder
___ Lumbago
___ Eczema

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 Extremeties

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

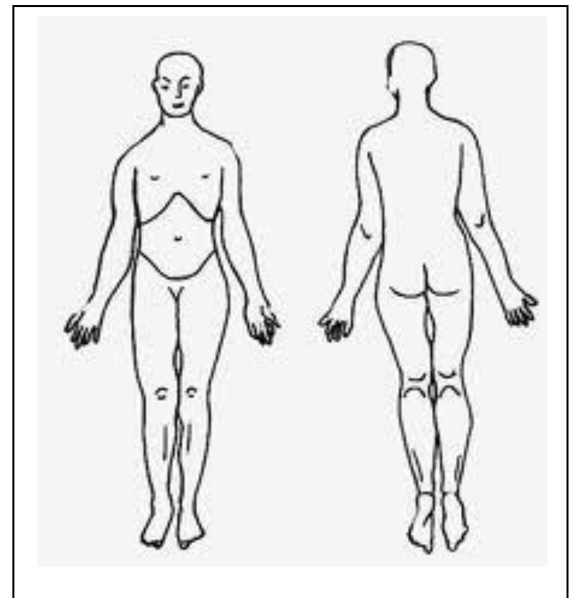
Genito-Urinary Code
___ Bladder Trouble.
___ Painful/Excessive Urination
___ Discolored Urine

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 ___



Please mark on the above diagram where you are having pain or discomfort