PATIENT HISTORY

Date:_____ **Name:** _____ **Patient #:**_____

History of Current Condition

Describe your major complaint: _____

Describe any secondary complaints: _____

When and How did the issue start? _____

Is it: ❑ Getting Better ❑ Getting Worse ❑ Staying the Same **Is it:** ❑ On & Off ❑ Constant

Is it: ❑ Sharp ❑ Stabbing ❑ Burning ❑ Achy ❑ Dull ❑ Stiff/Sore ❑ Hot ❑ Throbbing ❑ Numb

Does it radiate (travel or spread)? ❑ Yes, where_____ ❑ No

What, if anything, relieves your symptoms?

❑Heat ❑Ice ❑Rest ❑Stretches ❑Rx/OTC:_____ ❑Movement ❑Rubbing ❑Adjustment ❑Other: _____

What, if anything, worsens your symptoms?

❑Exercise ❑Sleep ❑Stretches ❑Movement ❑Sitting ❑Standing ❑Walking ❑Lifting ❑Reaching ❑ Other: _____

Please list any other day-to-day activities or movements that are more difficult to perform because of this problem:

Circle your discomfort level now: None (0) Mild (1-2) Mild-Mod (2-4) Moderate (4-6) Mod-Severe (6-8) Severe (8-10)

Write your discomfort level at it's worst: _____ at Best _____ on Average_____

Have you seen another healthcare professional for this problem? ❑ Yes, when?_____ ❑ No

What type of professional? ❑ MD/DO(Primary) ❑ MD/DO Specialist ❑ Chiropractor

Name: _____ ❑ Massage Therapist ❑ Physical Therapist ❑ Acupuncturist

❑Other:_____

What steps were recommended? ❑ X-ray/MRI ❑ Meds ❑ Exercises ❑ Surgery ❑ Other: _____

Did you follow the recommendations? ❑ Yes ❑ No, why?_____

Did it help? ❑ Yes ❑ No Please detail:_____

Have you had this complaint before? ❑ Yes, when _____ ❑ No

General Health History

At what Age was your 1st Chiropractic Adjustment?_____ **Have you been adjusted by a DC in the past?**_____

When was your last adjustment? (how long ago)_____ **Did the adjustment help your condition?** _____

Name of Chiropractor or Clinic: _____ **For what problem?** _____

Was a treatment plan recommended? _____ **Did you follow it?**_____

Did you continue with maintenance care?_____ **How many times per month?**_____

Medications and Supplements

Allergies to Medications: **NONE**

Name	Reaction

Current Medications & Supplements **NONE**

Name	Dosage	Frequency	Reason

Past Health History

# of Falls in the Last 24 Months: _____ **Injuries?** Y/N

Surgeries: **NONE**

Date	Area of the Body	Reason

Major Traumas/Hospitalizations/Autos: **NONE**

Date	Describe

Family Health History

Relevant Major Health Problems of 1st-Degree Relatives:
(ex: arthritis, scoliosis, stroke, cancer, high blood pressure, etc.)

Problem	Parent (M/F)	Sibling (B/S)	Child (S/D)

Social and Occupational History

Smoking/Tobacco Use: Current / Former / Never

Habit	Frequency	Type	Year Began
Tobacco			
Alcohol			
Caffeine			
Rec. Drugs			

Education: High School / College Grad / Post Grad / Other:

Lifestyle	Describe
Hobbies	
Recreation	
Exercise	
Diet	
Work	
Other	