Date_____

Personal History Form

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

First Name _____ Middle _____ Last _____
Nickname_____
Address_____ City _____ State ____ Zip_____
Social Security # _____
Gender ☐ Male ☐ Female Marital Status: Single
Spouse_____
Your D.O.B_____ Age_____
Home# _____ Work# _____ Cell# _____
E-Mail _____
Emergency Contact _____ Phone _____
Who Referred You? _____
Employer _____ Occupation _____
Employer Address_____
Have you ever been treated by a Chiropractor before? ☑ Yes ☐ No

PROBLEM FOCUSED HISTORY

What Is Your Chief Complaint(s)

1st 3rd
2nd 4th_____

How Would You Describe Your Chief Complaint At This Time?

Details of PRIMARY COMPLAINT:

1. Location of Symptoms
2. How did it happen?
3. Date when symptoms first appeared?
4. Did it begin: ☐ Gradually? ☐ Suddenly?
5. What makes symptoms better?
6. What makes symptoms worse?
7. Type of pain
   ☐ Sharp ☑ Burn ☐ Dull ☐ Throb ☐ Ache ☐ Other
8. Does pain radiate into your
   ☐ Arm ☐ Leg ☑ Does not radiate

Doctor's Notes:

9. Do you experience numbness or tingling?
   ☐ Yes ☑ No
10. How often do you experience symptoms?
   ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
11. Pain Intensity (0= No pain, 10= Excruciating!)
   ○0○1○2○3○4○5○6○7○8○9○10
12. Since Onset Symptoms/Dysfunction have:
   ☐ Decreased ☐ Increased ☐ Same ☐ Erratic
13. Changes in body functions?
   ☐Balance ☐Bowel Habits ☐Gait ☐Coordination
   ☐Sexual ☐Weight ☐Breathing ☐Grip
   ☐Urination ☐Coughing ☐Weakness ☐Sneezing
   ☐Hearing ☐Sleep ☐Menstrual ☐Vision
   ☐No changes in body functions
14. Changes in activities of daily living: Symptoms…
   ☐ Forgotten with Activity ☐ May Prevent Activity
   ☐ Prevent Activity ☑ Interfere with Activity
   ☐ Do Not Effect Activity
   ☐ Activity Continues Despite Problem
15. Work Status: Number of jobs 1 2 3
   ☐Full Time ☐Part Time ☐Homemaker ☐Student
   ☐Retired ☐Disabled ☐Unemployed ☐Shift 1 2 3
16. What are you doing for **this** complaint?
   ☐Store-bought or Home Remedies
   ☐Other Professional Care _____
   ☐Nothing ☐Other
17. Are you currently under a doctor's care for any other conditions? ☑Yes ☐No
18. Are you now or could you be pregnant? ☑Yes ☐No
19. Do you have any other complaints or conditions that we should know about? ☐Yes ☑No
20. Concerning this complaint, do you have any particular worries, concerns or fears? ☑Yes ☐No

Doctor's Notes:

_____
_____
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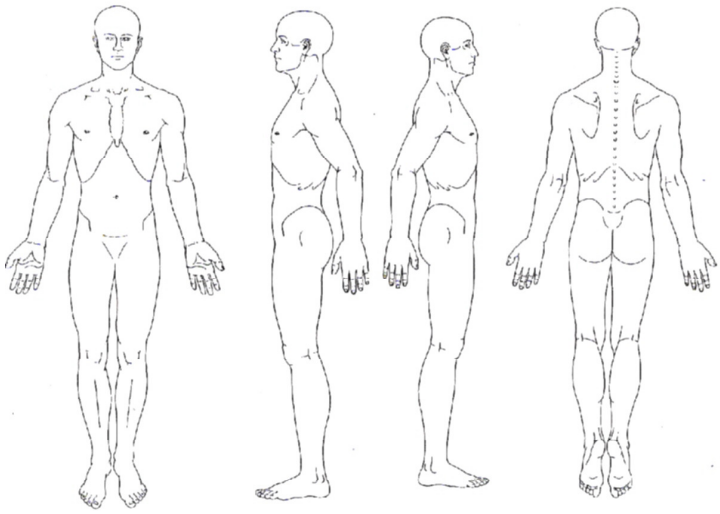
Please mark off the areas of your complaint on the diagram on the right. Please use the following symbols to describe your condition:

PPP-Pain
NNN-Numbness
TTT-Tingling
BBB-Burning
CCC-Cramping



Patient Signature_____ Date_____

Past Health History Review

Please answer the questions below concerning your **PAST HEALTH HISTORY**. Be sure to list all conditions or symptoms, **BOTH PAST AND PRESENT**.

Full Name_____ Date fgdgdf

REVIEW OF SYSTEMS:

1. Do you have bowel or digestive problems? (heart burn, irritable bowel, ulcers, etc) ☑Y ☐N
2. Do you have skin, hair or nail problems? ☐Y ☐N
3. Do you have thyroid problems? ☐Y ☐N
4. Do you have liver problems? ☐Y ☐N
5. Do you struggle with your weight? ☐Y ☐N
6. Do you have mouth or throat problems? ☐Y ☐N
7. Do you have blood or lymph node problems? ☑Y ☐N
8. Do you have allergy or immunity problems? ☐Y ☐N
9. Do you have night sweats or fevers? ☐Y ☐N
10. Do you have any recent infections? ☐Y ☐N
11. Do you have heart or blood vessel problems? ☐Y ☐N
12. Do you have cholesterol or triglyceride problems? ☐Y ☐N
13. Do you have blood sugar problems? ☐Y ☐N
14. Do you have chest or lung (breathing) problems? ☐Y ☐N
15. Do you have genital problems? (prostate, testicular, vaginal)? ☐Y ☐N
16. Do you have urinary problems? (including bladder and kidney) ☐Y ☐N
17. Do you have any gland or hormone problems? ☑Y ☐N
18. Do you have any nervous system or mental health problems? ☐Y ☐N
19. Do you have any eye problems? ☐Y ☐N
20. Do you have any ear problems? ☐Y ☐N
21. Do you have any muscle, tendon or ligament problems? ☐Y ☐N
22. Do you have any bone or joint disease? (bone=osteoporosis joint= arthritis) ☑Y ☐N

Doctor's Notes:

23. FEMALES ONLY

Have you had menstrual problems? ☐Y ☐N
Have you taken birth control pills? ☑Y ☐N
Have you taken Hormone Replacement? ☐Y ☐N
Is there any chance you are pregnant? ☐Y ☐N
Do you have breast problems? ☐Y ☑N
Date of last Pap or Breast Exam _____

Doctor's Notes

Patient Signature tewtwet Date 234

MEDICAL HISTORY:

24. Have you ever been diagnosed or told you have the following?

☐Stroke ☐TIAs (mini strokes) ☐Heart disease ☐Osteoporosis
☐Arthritis ☐Hardening of Arteries ☐Aneurysms ☐Fracture
☐Broken Vertebra ☐Cancer ☐Herniated or Slipped discs ☐Bleeding Disorders
☐I have never been diagnosed with any of the above

25. Please tell us if you have ever been diagnosed as having any other condition such as diabetes, AIDS, high blood pressure, high cholesterol, etc.

26. Please list any surgeries you have had (don't forget appendix, tonsils, ear tubes, etc.):

date
date
date
date

27. List any surgical/medical implanted devices (pace makers, pumps, joints, breasts, rods, screws, staples, etc.)

28. Have you ever been hospitalized for any reason other than surgery? ☐Y ☐N

29. Are you currently under care for mental health reasons? ☐Y ☐N

30. Are you currently taking medications? ☐Y ☐N
If so, please list all medications, including over the counter medications you are taking/have taken in the past five years.

31. Are you currently taking vitamins/minerals or supplements? ☐Y ☐N
If so, please list all of the vitamins/minerals or supplements you are taking/have taken in the past few years.

Doctor's Notes:

Patient Signature qddf Date 234

32. Do you drink coffee or black tea? ☐Y ☐N If so, how much per day?
33. Do you smoke tobacco? ☐Y ☐N If so, how much per day?
34. Do you drink alcohol? ☐Y ☐N If so, how often?_____
35 Do you drink soda, energy or sport drinks? ☐Y ☐N If so, how much per day?
36. Date of last Physical Exam
37. Date of last X-rays
38. Date of last Blood Study
39.Allergies

FAMILY HISTORY:

40. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)?

Additional Questions:

41. Do you have problems with recurring headaches? ☐Y ☐N
42. Are you losing weight without trying? ☐Y ☐N
43. Does your pain wake you at night? ☐Y ☐N
44. Have you had a change in bowel or bladder habits? ☐Y ☐N
45. Have you had a sore that doesn't heal? ☐Y ☐N
46. Have you recently had any unusual bleeding or discharge? ☐Y ☐N
47. Do you have a thickening/lump in the breast or elsewhere? ☐Y ☐N
48. Do you have indigestion or difficulty swallowing? ☐Y ☐N
49. Have you had an obvious change in a wart or mole? ☐Y ☐N
50. Do you have a nagging cough or hoarseness? ☐Y ☐N

51. Is there anything about your past history not asked that we should know?

52.Who is your:
Medical Doctor?
OB/Gyn?
Dentist?

Doctor's Notes:

Patient Signature addf_____ Date 234

Lifestyle and Wellness Survey

Recent scientific studies have shown a strong connection between a person's overall health and wellness and their lifestyle habits. Please answer the questions below as accurately as possible to help us determine if your health and future wellness are being compromised by your lifestyle.

Full Name: _____

Date: fadadf_____ **Age:** _____ **Occupation:** _____

Diet:

1. Do you eat breakfast every day? ☑ Yes ☐ No

2. Do you eat at least 3 meals a day? ☐ Yes ☑ No

3. How many times a week do you eat restaurant food?
- ☐ 0-3x per week
- ☑ 4-7x per week
- ☐ 8-10x per week
- ☐ More

4. What % of your diet is fresh fruit and vegetables?
- ☐ 0-25%
- ☐ 26-50%
- ☑ 51-75%
- ☐ 76-100%

5. How often do you eat candy, sweets & desserts?
- ☐ 0-3x per week
- ☐ 4-7x per week
- ☑ 8-10x per week
- ☐ Daily
- ☐ I never eat candy, sweets & desserts

6. Your diet is:
- ☐ balanced
- ☐ fair
- ☐ poor
- ☐ excessive
- ☑ restricted

7. Have you tried any diets? ☐ Yes ☑ No

8. Do you use:
- ☐ coffee
- ☐ tea
- ☐ tobacco
- ☐ recreational drugs
- ☐ alcohol
- ☐ I do not use any of the above

9. Do you use:

- ☐ soda
- ☐ sports drinks
- ☐ energy drinks
- ☐ I do not use any of the above

10. Are you satisfied with your eating habits? ☐ Yes ☐ No

EXERCISE:

1. Do you exercise on a regular basis? ☐ Yes ☐ No

2. How many times a week do you aerobic exercise?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ daily

3. How many times a week do you strength train?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ daily

4. How many times a week do you stretch?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ daily

5. Are you satisfied with your exercise results? ☐ Yes ☐ No

STRESS MANAGEMENT:

1. I am getting at least 20 minutes of relaxation each day? ☐Yes☐No

Type of Relaxation:

2. I am currently getting a restful night's sleep? ☐Yes☐No

3. How many hours per night? _____

4. Do you snore? ☐Yes ☐No

5. I worry a lot about:

- ☐ myself
- ☐ family
- ☐ spouse
- ☐ work
- ☐ finances
- ☐ world problems
- ☐ other

6. Describe your work.

Type:

- ☐ Professional
- ☐ Physical Labor
- ☐ Driver
- ☐ Clerical
- ☐ Factory
- ☐ Homemaker

Physical Demands:

- ☐ Heavy
- ☐ Moderate
- ☐ Mild
- ☐ Sedentary

Stress Level:

- ☐ High
- ☐ Medium
- ☐ Low

7. Do you:

- ☐ read newspapers
- ☐ watch the news
- ☐ listen to talk radio
- ☐ frequent the internet
- ☐ other

8. How do you spend your spare time? (hobbies, etc.)

9. Do you have any concerns or considerations that you might contract serious diseases, disorders or conditions - if so, what?