

## PATIENT HISTORY AND APPLICATION FOR CHIROPRACTIC CARE

Date \_\_\_\_\_  
Patient's Name \_\_\_\_\_  
Home Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Birth Date \_\_\_\_\_  
Phone # \_\_\_\_\_

Social Security # \_\_\_\_\_  
Referred By \_\_\_\_\_  
Where Do You Work? \_\_\_\_\_  
Occupation \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone # \_\_\_\_\_

If a minor, name and address of person responsible  
for care: \_\_\_\_\_  
\_\_\_\_\_

I give permission for this minor to be seen at this office.

Signature \_\_\_\_\_ Relation to patient \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please give today's pain/problems a number, with  
"10" representing the most severe expression and "1"  
representing the most minimal.

When did this problem start? \_\_\_\_\_

1. \_\_\_\_\_

When did this incident begin? \_\_\_\_\_

2. \_\_\_\_\_

Have you had this before? \_\_\_\_\_

3. \_\_\_\_\_

If so, does today's problem feel any different? \_\_\_\_\_

4. \_\_\_\_\_

Have you been out of work for the above? \_\_\_\_\_

Do any of the above problems interfere with the way  
you go about your day? \_\_\_\_\_

When? \_\_\_\_\_

In what way? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Full or Part Time? \_\_\_\_\_

Is this visit for injuries received during an auto accident or  
worker's compensation case? \_\_\_\_\_

If this case is still open, stop writing and go to the front desk  
for the appropriate forms. Without it, we cannot do any of the  
paperwork necessary to file your claim. The original paper-  
work must be completed before you are seen today.

Have you ever gone to a chiropractor before? \_\_\_\_\_

When was your last adjustment? \_\_\_\_\_

The techniques that worked best for me were: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(OFFICE USE ONLY) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name \_\_\_\_\_

PERSONAL HEALTH HISTORY

Are you currently taking any medication (prescription or over the counter)? \_\_\_\_\_

If so, what? And why? \_\_\_\_\_

Have you ever had the following?

- |                            |                 |                      |
|----------------------------|-----------------|----------------------|
| _____ heart disease        | _____ seizures  | _____ allergy        |
| _____ gall bladder disease | _____ arthritis | _____ hypertension   |
| _____ diabetes             | _____ stroke    | _____ ulcers         |
| _____ cancer               | _____ TB        | _____ kidney disease |
| _____ headache             | _____ asthma    | _____ fainting       |

If you checked any of the above, please explain below: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



FAMILY HEALTH HISTORY

Age of: Mother _____
Father _____

Has anyone in the family ever had any of the following?

- |  |                            |
|--|----------------------------|
| _____ heart disease                      | _____ arthritis            |
| _____ hypertension (high blood pressure) | _____ gall bladder disease |
| _____ diabetes                           | _____ kidney disease       |
| _____ TB                                 | _____ allergies            |
| _____ asthma                             | _____ fainting             |
| _____ other                              |                            |
| _____ ulcers                             |                            |
| _____ cancer                             |                            |
| _____ epilepsy, seizures                 |                            |

If you checked any of the above, please explain below: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

When was your last physical examination? \_\_\_\_\_

Results? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(OFFICE USE ONLY) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



GYNECOLOGICAL HISTORY

Onset of period \_\_\_\_\_ years                      Length \_\_\_\_\_ days                      Pain \_\_\_\_\_

Number of pregnancies \_\_\_\_\_                      Number of children \_\_\_\_\_

Problems: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient Name \_\_\_\_\_

**SURGICAL HISTORY**

Describe any and all surgeries \_\_\_\_\_

\_\_\_\_\_

**TRAUMA**

Describe any trauma (auto accidents, falls, blows, major sports injuries), regardless of age at the time, including care received: \_\_\_\_\_

\_\_\_\_\_

Physical attacks/abuse: \_\_\_\_\_

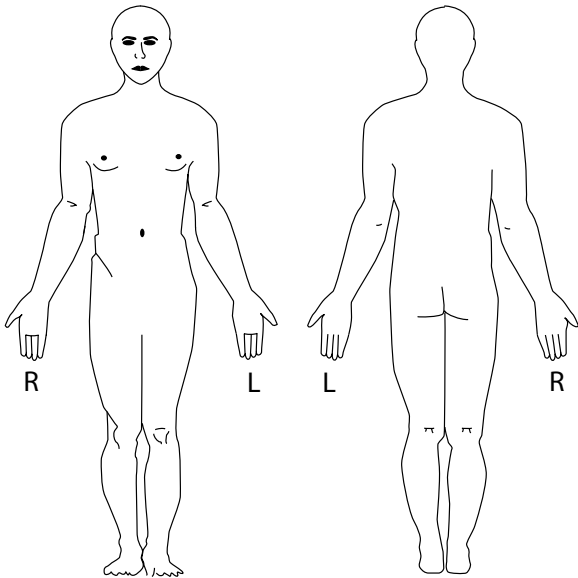
Have you ever broken a bone? \_\_\_\_\_ Describe: \_\_\_\_\_

\_\_\_\_\_



**SYMPTOMS**

Shade in areas of pain or abnormal sensation.



Do you ever have the following? (Check all that apply)

- \_\_\_\_\_ neck pain<sup>1</sup>
- \_\_\_\_\_ pain between shoulders<sup>2</sup>
- \_\_\_\_\_ low back pain<sup>3</sup>
- \_\_\_\_\_ weakness<sup>4</sup>
- \_\_\_\_\_ poor balance<sup>5</sup>
- \_\_\_\_\_ paralysis<sup>6</sup>
- \_\_\_\_\_ colds<sup>7</sup>
- \_\_\_\_\_ insomnia<sup>8</sup>
- \_\_\_\_\_ stomach pain<sup>9</sup>
- \_\_\_\_\_ poor appetite<sup>10</sup>
- \_\_\_\_\_ bowel problems<sup>11</sup>
- \_\_\_\_\_ urinary problems<sup>12</sup>
- \_\_\_\_\_ general poor health<sup>13</sup>
- \_\_\_\_\_ jaw pain<sup>14</sup>
- \_\_\_\_\_ itching<sup>15</sup>
- \_\_\_\_\_ ringing in the ears<sup>16</sup>
- \_\_\_\_\_ knee Pain<sup>17</sup>    \_\_R\_\_ L
- \_\_\_\_\_ elbow Pain<sup>18</sup>    \_\_R\_\_ L
- \_\_\_\_\_ shoulder Pain<sup>19</sup>    \_\_R\_\_ L
- \_\_\_\_\_ leg Pain<sup>20</sup>    \_\_R\_\_ L
- \_\_\_\_\_ arm Pain<sup>21</sup>    \_\_R\_\_ L
- \_\_\_\_\_ foot Pain<sup>22</sup>    \_\_R\_\_ L
- \_\_\_\_\_ hand Pain<sup>23</sup>    \_\_R\_\_ L
- \_\_\_\_\_ unexplained weight loss<sup>24</sup>
- \_\_\_\_\_ nausea/vomiting<sup>25</sup>
- \_\_\_\_\_ dizziness<sup>26</sup>
- \_\_\_\_\_ shortness of breath<sup>27</sup>
- \_\_\_\_\_ numbness or tingling<sup>28</sup>
- Where? \_\_\_\_\_
- \_\_\_\_\_ visual difficulty (excluding glasses)<sup>29</sup>
- \_\_\_\_\_ hearing problems<sup>30</sup>
- \_\_\_\_\_ difficulty swallowing<sup>31</sup>
- \_\_\_\_\_ trouble taking a deep breath<sup>32</sup>
- \_\_\_\_\_ difficulty speaking<sup>33</sup>

Explain any of the above you have checked: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

