

CONFIDENTIAL PATIENT HISTORY

Date _____

Name _____ Soc. Sec. _____ CA Dr.Lic.# _____

Address _____ How long at this address? _____

City _____ State _____ Zip _____ Email _____

Home Phone _____ Work Phone _____ x _____ Cell Phone _____

Age _____ Birth date _____ Occupation _____

Marital Status S M W D No. of children _____ Spouse's Name _____

Employer _____ No. Yrs Employed _____

Person responsible for this account _____

Emergency contact person _____

Address _____ Phone _____

How were you referred to this office? _____

This is a comprehensive health history that will provide us a detailed look at your past and present state of health. Please complete this form so we can better understand your current condition. This information is strictly confidential. Please circle the appropriate symbol or put a check in the appropriate box. (Y=Yes, N=No, ?=don't know)

Early History: Was your birth traumatic Y N ? Were forceps used Y N ? Cesarean section Y N ?
Were you given immunizations Y N ? Did you have adverse reactions Y N ? If so, would you please describe

Describe your childhood health/list childhood diseases _____

Past History: Please list any major traumas, broken bones, sports injuries, or falls with year of occurrence

Have you had Chiropractic care before Y N (If yes, please state for what reason, when, by whom and your results)

Please list surgical operations and dates _____

Please list hospitalizations/major illnesses _____

Please list X-rays/CT/MRI taken (give dates and locations) _____

Family History: Is there a history of spinal problems in your family Y N ?

Who _____ Describe _____

Are there other health problems that run in your family Y N ? Describe _____

Current Complaints: What is your major complaint _____

What caused this condition _____

When did this start? _____ Have you had this before? Y N

What aggravates it _____

What relieves it _____

Is it getting worse Y N ?

Does it come and go Y N ?

How often are the complaints present?

___ Constant (76-100%) ___ Frequent (51-75%) ___ Occasional (26-50%) ___ Intermittent (25% or less)

Is there a time of day that it is worse _____ Better _____ Does it wake you from a deep sleep Y N ?

Is it interfering with your : Work Y N ? Sleep Y N ? Recreations Y N ? Daily routine Y N ?

Would you say your complaint is: ___ An annoyance ___ Mild ___ Moderate ___ Severe

What have you done for this at home _____

Other complaints _____

Are you taking medications or non-prescription Y N List _____

Are you taking herbal remedies or natural supplements Y N List _____

Other doctors seen for this condition _____

Diagnosis: _____

Treatments: _____ Results: _____

Have you seen a doctor for other conditions in the last year Y N ? If yes, please describe _____

When do you seek health care?

_____ Only for pain/symptoms _____ To prevent symptoms/disease _____ To maximize health/wellness

What level of care are you interested in?

_____ Symptom relief only _____ Achieving optimal spinal function _____ Prevention care

I understand that fees are to be paid at the time services are rendered unless other financial arrangements are made in advance.

Patient signature (or guardian) _____ Date _____

