

DATE _____

ID # _____

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State _____ Zip Code _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex M F

Cell Phone: _____ Social Security # _____

Email: _____ Single Married Widowed Divorced Separated

Business Employer: _____ Occupation: _____

Business Phone: _____ Best Phone # to Reach You: _____

Name of Spouse: _____ Name/Ages of Children: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Referred to This Office By: Person _____ Mailer Newspaper Website Other

Name and Number of Emergency Contact: _____ Relationship: _____

CURRENT HEALTH CONDITION

Unwanted Health Condition: _____

Other Doctors Seen For This Condition: Yes No Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No

Is Condition: Job Related Auto Accident Home Injury Fall Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made a Report of Your Accident to Your Employer/Auto Insurance carrier? Yes No

Who is Your Current Primary Care Physician? _____

When Was the Last Time You Saw Him/Her? _____ Reason: _____

Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine Insulin

Other: _____

Do You Wear a Shoe Lift? Yes No

Do You Suffer From Any Other Condition Other Than Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery

Broken Bones Other _____

Major Accidents or Falls: _____

Hospitalizations (Other Than Above): _____

Previous Chiropractic Care: None Doctor's Name & Approximate date of Last Visit _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | INTAKE |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | |

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- | | |
|---|---|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Gas/Bloating After Meals |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Black/Bloody Stools |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Joint Pain/Stiffness | |
| <input type="checkbox"/> Walking Problems | |
| <input type="checkbox"/> Difficult Chewing/Clicking Jaw | |
| <input type="checkbox"/> General Stiffness | |

GENITO-URINARY CODE

- Bladder Troubles
- Painful/Excessive Urination
- Discolored Urine

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

EENT CODE

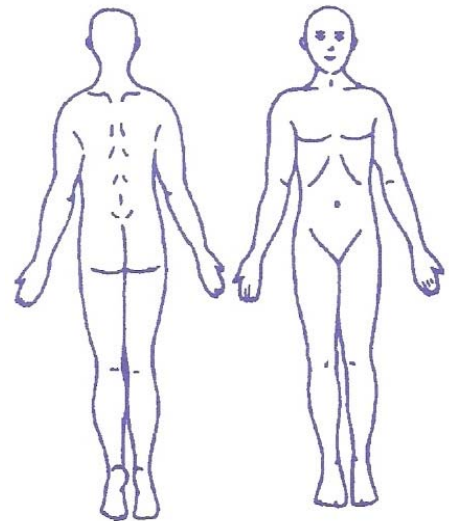
- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulties
- Stuffed Nose

GASTRO-INTESTINAL CODE MALE/FEMALE CODE

- | | |
|--|--|
| <input type="checkbox"/> Poor/Excessive Appetite | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Frequent Nausea | <input type="checkbox"/> Vaginal Pain/Infection |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Breast Pain/Lumps |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Prostate/sexual Dysfunction |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Other Problems |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Gall Bladder problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Weight Problems | |
| <input type="checkbox"/> Abdominal Cramps | |

FEMALES ONLY:

When was your last period? _____
 First day of last period? _____
 Are you pregnant?
 Yes No Unsure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

Doctor Name _____

Doctor Signature _____

Date: _____

Employment, ADL, and Recreation Information

Please fill in your name and then answer the questions below indicating how your current condition affects your ability to perform the activities listed.

Patient name _____ File # _____ Date _____

Initial Exam _____ Re-activation _____ Re-evaluation Exam _____

Description of Work: _____

Condition's Effect On Job Performance: **No Effect** **Mild** (painful can do) **Mod** (painful limited ability)
 Mod/Sev (limited duty) **Sev** (no limited duty) **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

- Bending: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Care –Infirm Family: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Carrying Groceries: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Change Posn–Sit–Stand: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Climb Stairs: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Driving: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Extended Computer Use: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Feeding: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Household Chores: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Kneeling: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Lift Children: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Lifting: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Pet Care: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Reading (Concentration): **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care–Bathing: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care–Dressing: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care–Shaving: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Sexual Activities: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Sleep: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Static Sitting: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Static Standing: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Walking: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Yard Work: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

- _____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform
- _____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform
- _____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform

Attending Doctor's Signature _____ Date _____