PERSONAL HISTORY

Dear Patient, welcome to our clinic, this form is designed to help us get to the cause of your current health problem as quickly as possible. The more detailed and accurate you are, the better care we can provide. Your overall health is just as important to us as your current mqjor complaints. No symptom is insignificant. The more you tell us, the more we will be able to help you achieve your health goals.

Date: _____ Chart Number: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Birthdate: _____

Age: _____ Sex: M F Height: _____ Weight: _____

Business/Employer: _____ Type of work: _____

Check one: ☐ Married ☐ Single ☐ Divorced ☐ Separated

SS# _____ Spouse's Name: _____ No. of Children: _____

Referred to this office by: _____

Are you/have you been disabled from work? _____

Current Medications:

☐ Tranquilizers ☐ Pain Killers / Muscle Relaxants ☐ Blood Pressure

☐ Insulin ☐ Aspirin / Similar ☐ Hormones ☐ Other

Specific drug or substance: _____

Natural Remedies: Vitamins / Minerals: _____

Herbs: _____

Homeopathics: _____

CURRENT HEALTH CONDITIONS

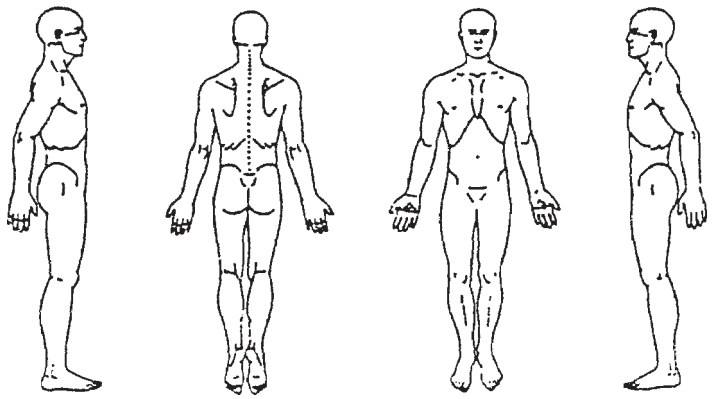
Please fill out one section for each major complaint, starting with the one you feel is most significant, indicate on drawings where your pain is located.

1. MAJOR COMPLAINT: _____ Date of onset: _____ ☐ Sudden ☐ Gradual

How bad is your pain or ache? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Describe your pain or complaint:

1. ☐ Dull ☐ Sharp ☐ Ache ☐ Stabbing
   ☐ Deep ☐ Superficial ☐ Spasm / Tension ☐ Numbness
   ☐ Tingling ☐ Burning ☐ Other
2. Radiation: Does the pain go to other parts of the body?
   ☐ Yes ☐ No Where? _____
3. Frequency: ☐ Occasional ☐ Intermittent ☐ Constant
4. Duration: How long does the pain last? _____
5. What makes the pain worse?
   ☐ Standing ☐ Sitting ☐ Bending ☐ Twisting
   ☐ Walking ☐ Lifting ☐ Sleeping ☐ Heat
   ☐ Cold ☐ Stooping ☐ Sex ☐ Other
6. What makes the pain better?
   ☐ Sitting ☐ Standing ☐ Rest ☐ Heat
   ☐ Cold ☐ Aspirin / Medication ☐ Other
7. Other problems related to your main complaint: _____
8. What treatment have you received for this condition? _____

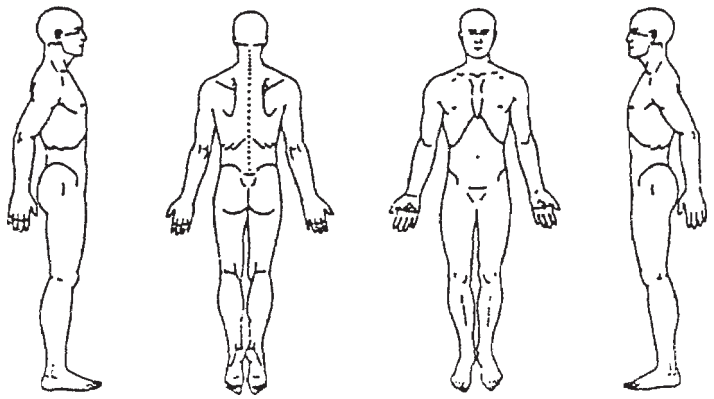


2. MAJOR COMPLAINT: _____ Date of onset: _____ ☐ Sudden ☐ Gradual

How bad is your pain or ache? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Describe your pain or complaint:

1. ☐ Dull ☐ Sharp ☐ Ache ☐ Stabbing
   ☐ Deep ☐ Superficial ☐ Spasm / Tension ☐ Numbness
   ☐ Tingling ☐ Burning ☐ Other
2. Radiation: Does the pain go to other parts of the body?
   ☐ Yes ☐ No Where? _____
3. Frequency: ☐ Occasional ☐ Intermittent ☐ Constant
4. Duration: How long does the pain last? _____
5. What makes the pain worse?
   ☐ Standing ☐ Sitting ☐ Bending ☐ Twisting
   ☐ Walking ☐ Lifting ☐ Sleeping ☐ Heat
   ☐ Cold ☐ Stooping ☐ Sex ☐ Other
6. What makes the pain better?
   ☐ Sitting ☐ Standing ☐ Rest ☐ Heat
   ☐ Cold ☐ Aspirin / Medication ☐ Other
7. Other problems related to your main complaint: _____
8. What treatment have you received for this condition? _____

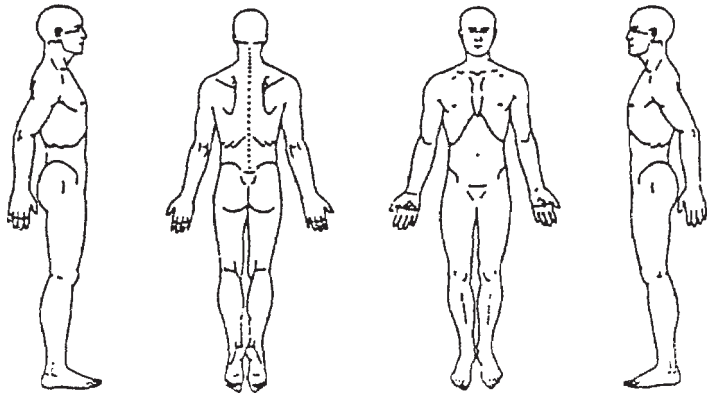


1. MINOR COMPLAINT: _____ Date of onset: _____ ☐ Sudden ☐ Gradual

How bad is your pain or ache? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Describe your pain or complaint:

1. ☐ Dull ☐ Sharp ☐ Ache ☐ Stabbing
   ☐ Deep ☐ Superficial ☐ Spasm / Tension ☐ Numbness
   ☐ Tingling ☐ Burning ☐ Other
2. Radiation: Does the pain go to other parts of the body?
   ☐ Yes ☐ No Where? _____
3. Frequency: ☐ Occasional ☐ Intermittent ☐ Constant
4. Duration: How long does the pain last? _____
5. What makes the pain worse?
   ☐ Standing ☐ Sitting ☐ Bending ☐ Twisting
   ☐ Walking ☐ Lifting ☐ Sleeping ☐ Heat
   ☐ Cold ☐ Stooping ☐ Sex ☐ Other
6. What makes the pain better?
   ☐ Sitting ☐ Standing ☐ Rest ☐ Heat
   ☐ Cold ☐ Aspirin / Medication ☐ Other
7. Other problems related to your main complaint: _____
8. What treatment have you received for this condition? _____



PAST HEALTH HISTORY

List all surgery with dates: _____

_____

Any major or minor accidents (include "fender benders") and falls (gymnastics, horse, etc.): _____

_____

Hospitalization (other than above): _____

Previous Chiropractic care: ☐ Yes ☐ No Dr.'s Name _____

Date of last visit: _____ Condition treated: _____ X-rays taken: _____

Last medical physical: _____ Most recent blood work: _____

Check any of the following conditions you have experienced other than your current major complaints:

1. MUSCULO-SKELETAL

	Past	Present	Mild	Moderate	Severe
Low back pain	☐	☐	☐	☐	☐
Pain between shoulders	☐	☐	☐	☐	☐
Neck	☐	☐	☐	☐	☐
Arm pain / numbness / weakness	☐	☐	☐	☐	☐
Joint pain / stiffness	☐	☐	☐	☐	☐
Walking problems	☐	☐	☐	☐	☐
Muscle cramps	☐	☐	☐	☐	☐

	Past	Present	Mild	Moderate	Severe
Leg pain / numbness / weakness	☐	☐	☐	☐	☐
General stiffness	☐	☐	☐	☐	☐
Fractures	☐	☐	☐	☐	☐
Foot / Ankle problems	☐	☐	☐	☐	☐
Difficult chewing / clicking jaw	☐	☐	☐	☐	☐
Shoulder problems	☐	☐	☐	☐	☐
Knee problems	☐	☐	☐	☐	☐
Hip problems	☐	☐	☐	☐	☐

2. NERVOUS SYSTEM

☐ Nervousness:
Do you consider yourself to be a "nervous type" in general? _____
Are you feeling nervous about something specific? _____

☐ Forgetfulness:
Are you forgetting recent events? _____
Events from the distant past? _____
Do you forget other things? _____
Is memory worse with stress? _____

☐ Numbness:
Where? _____
When did it start? _____
Frequency: ☐ Occasional ☐ Intermittent ☐ Constant

☐ Dizziness: ☐ Past ☐ Present

☐ Fainting: ☐ Past ☐ Present

☐ Stress: ☐ Past ☐ Present Rate your level of stress on a scale of 1 to 10:
Please circle a number: 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

☐ Depression: ☐ Past ☐ Present
If present, how long have you been depressed? _____
Have you ever taken prescribed medications for depression? ☐ Yes ☐ No
If yes, list medications _____
Are you getting professional counseling? ☐ Yes ☐ No Is there a family history of depression? ☐ Yes ☐ No
Is your current depression related to a specific situation? ☐ Yes ☐ No
Is your depression: ☐ Mild ☐ Moderat ☐ Severe

☐ Cold or Tingling Extremities: ☐ Hands ☐ Feet ☐ Both Date of onset: _____
Frequency: ☐ Occasional ☐ Intermittent ☐ Constant

3. GENERAL

☐ Fatigue: ☐ Past ☐ Present If present: ☐ Mild ☐ Moderate ☐ Severe Daily? ☐ Yes ☐ No
Is there a pattern? Describe:

☐ Headaches: ☐ Past ☐ Present If present, how frequent: ☐ Daily ☐ Weekly ☐ Monthly
Degree: ☐ Mild ☐ Moderate ☐ Severe Location of pain: _____
Is there a pattern? Describe: _____
How long has this pattern of headaches existed (days / weeks / months / years)? _____
Do you have any idea what causes or triggers your headaches? _____
Females only: Is there a relationship to your menstrual cycle? ☐ Yes ☐ No

☐ Allergies: ☐ Airborne ☐ Food ☐ Unknown
List known allergies: _____
How often? Daily / weekly / monthly, or if "seasonal" which seasons? _____
What kind of symptoms do you have with your allergies? _____

☐ Bleeding Tendencies: Where? _____ How often? _____
How severely? _____
How long have you had this problem? _____

☐ Loss of Sleep: ☐ Past ☐ Present If present, how frequently does this occur? _____
When did this pattern begin? _____
Do you have difficulty falling asleep or staying asleep? (check one or both) ☐ Yes ☐ No
What factors do you think cause or influence this condition? _____

☐ Skin Conditions: ☐ Past ☐ Present
Describe condition: _____
List past treatments and effectiveness: _____

☐ Fever:
When was your last fever? _____
How often do you get fevers? _____
How severe do they get? _____

4. GENITRO URINARY

☐ Bladder Infections:
When was your last one? _____ How often do you have one? (per year) _____
What factors do you think cause or influence this condition? _____

☐ Frequent Urination: (other than associated with bladder infections) How frequent? (times per day) _____

☐ Discolored Urine: ☐ Past ☐ Present If present, when did it begin? _____

☐ Incontinence: ☐ Past ☐ Present If present when did it begin? _____

☐ Dribbling: ☐ Past ☐ Present If present when did it begin? _____

☐ Blood in Urine: ☐ Past ☐ Present If present when did it begin? _____

5. CARDIOVASCULAR/RESPIRATORY

☐ Chest Pain: ☐ Past ☐ Present If present, when does it occur? _____
Treatment? _____

☐ Shortness of Breath: ☐ Past ☐ Present When does it occur? _____

☐ Heart Disease: ☐ Past ☐ Present
Describe: _____

☐ Ankle Swelling: ☐ Past ☐ Present If present is it constant? _____

☐ Blood Pressure Problems: ☐ Past ☐ Present ☐ High ☐ Low
Medication: _____

☐ Lung Problems / Congestion:
Describe: _____

☐ Stroke: When? _____
Residual problems? _____

☐ Chronic Cough: When did it start? _____ Are you a smoker? _____

☐ Irregular Heartbeat / Murmurs (circle one or both): _____
Describe:
Have you seen a medical doctor for this? _____

☐ Varicose Veins: ☐ Past ☐ Present
When did they start? _____ Are they painful? _____
What aggravates them? _____

6. EYES, EARS, NOSE AND THROAT

☐ Vision Problems: ☐ Past ☐ Present Specify problem: When did it begin? _____
List treatments: _____

☐ Earaches / lnfections: ☐ Past ☐ Present When was the last episode? _____
How often do they occur? _____ Severity of the problem? _____
List treatment: _____

☐ Dental History:
List present problems: _____
List past problems: _____
Have you ever had braces / orthodontics? _____ Did they pull teeth as part of your orthodontic treatment? ☐ Yes ☐ No
If yes, how many? _____ Who is your present dentist? _____

☐ Hearing Difficulty: ☐ Past ☐ Present
Please describe: _____
When did it begin? _____ List any treatment and its effectiveness: _____

☐ Sore Throat: ☐ Past ☐ Present
If present. when did it begin? _____ How severe is it? _____
What do you think caused or influenced this condition? _____
List any treatment and its effectiveness: _____

☐ Nose and Sinus Problems: ☐ Past ☐ Present
Describe: _____
When did it begin? _____
How severe is it? _____
What do you think causes or influences this condition? _____
List any treatment and its effectiveness: _____

☐ Noises in Ear: ☐ Past ☐ Present
Describe: _____
When did this begin? _____
What do you think causes or influences this condition? _____

7. GASTRO-INTESTINAL

Poor / Excessive Appetite (circle one or both): ☐ Past ☐ Present When did it start? _____
Do you feel you have an unhealthy relationship with food? ☐ Yes ☐ No Are you a compulsive eater? ☐ Yes ☐ No
Are you or have you ever been considered: ☐ Anorexic ☐ Bulimic
Do you feel over-concerned or obsessed with your weight and / or body image? ☐ Yes ☐ No

☐ Diarrhea: ☐ Past ☐ Present If present, frequency: ☐ Occasional ☐ Intermittent ☐ Constant
When did it start? _____
What do you think causes or influences it? _____
Is it related to: ☐ Specific foods ☐ Stress

☐ Gall Bladder Problems: ☐ Past ☐ Present If present, describe symptoms: _____

☐ Liver Problems: ☐ Past ☐ Present If present, describe symptoms: _____

☐ Heartburn: Frequency: ☐ Occasional ☐ Intermittent ☐ Constant
All foods? _____
Certain foods only? _____
Is there a time of day when it's worse? _____

☐ Excessive Thirst: ☐ Past ☐ Present When did it begin? _____

☐ Constipation: ☐ Past ☐ Present If present, when did it begin? _____
Is this a lifetime pattern? ☐ Yes ☐ No
What do you think causes or influences this condition? _____
Do you take any medications or natural substances to assist in bowel function? (list) _____

☐ Weight Change: As an adult, what has your weight range been? High: _____ Low: _____

☐ Black/Bloody Stool: ☐ Past ☐ Present When did it start? _____

☐ Ulcers: When? _____
Treatment? _____

☐ Nausea: ☐ Past ☐ Present If present, frequency: ☐ Occasional ☐ Intermittent ☐ Constant
Time of day _____ Certain foods? _____ Other factors? _____

☐ Hemorrhoids: ☐ Past ☐ Present Are they: ☐ Painful ☐ Bleeding
What factors affect it? _____

☐ Abdominal Cramps/Pain: ☐ Past ☐ Present If present, location: _____
When do they occur? Intensity: ☐ Mild ☐ Moderate ☐ Severe

☐ Hepatitis: ☐ Past ☐ Present When did it start? _____

☐ Vomiting: ☐ Past ☐ Present If present, when did it start? _____

☐ Colitis: ☐ Past ☐ Present If present, when did it start? _____
What factors effect it? _____

☐ Gas / Bloating After Meals: Certain foods? ☐ Past ☐ Present If present, all meals? ☐ Yes ☐ No

8. FEMALE PROBLEMS

Your age at first period: _____ How many days do you flow? _____
Most recent period began, date: _____ How many days from period to period? _____
Last PAP smear: _____ History of abnormal PAP? ☐ Yes ☐ No
If abnormal what class? _____
Treatment? _____

Contraception (present): _____
Past history of birth control pill use: How long? _____ Side effects? _____
Number of pregnancies: _____ Live births _____ Are you pregnant now? ☐ Yes ☐ No ☐ Unsure

☐ Menstrual Cramping: ☐ Mild ☐ Moderate ☐ Severe
Do you get cramps every month? ☐ Yes ☐ No If not, how often? _____

☐ Spotting

☐ PMS (Pre-menstrual Syndrome): ☐ Yes ☐ No If yes: ☐ Mild ☐ Moderate ☐ Severe
How many days of symptoms before your period? _____
Check symptoms:
☐ Breast tenderness ☐ Food cravings ☐ Irritability
☐ Crying easily ☐ Bloating / Weight gain ☐ Suicidal
☐ Other _____

☐ Painful Intercourse: ☐ Past ☐ Present

☐ Breast Lumps / Fibrocystic: ☐ Past ☐ Present

☐ Vaginal Infections / Yeast: ☐ Past ☐ Present Frequency, how many times per year? _____

☐ DES Mother

☐ Sexual Dysfunction: ☐ Past ☐ Present Describe: _____

☐ Ovarian, Vaginal, or Uterine Problems: ☐ Past ☐ Present

☐ Infertility: ☐ Past ☐ Present Treatment: _____

9. MALE PROBLEMS

☐ Prostate Problems: ☐ Past ☐ Present If present, describe symptoms: _____
When did this begin? _____
List any treatmnt and its effectiveness: _____

☐ Incomplete Voiding of Urine: ☐ Past ☐ Present If present, describe symptoms: _____
When did this begin? _____
List any treatment and its effectiveness: _____

☐ Pain during Urination: ☐ Past ☐ Present
If present, describe symptoms: _____
List any treatment and its effectiveness: _____ When did this begin? _____

☐ Sexual Dysfunction: ☐ Past ☐ Present
If present, describe symptoms: _____
List any treatment and its effectiveness: _____ When did this begin? _____

10. DISEASE

Check any of the following diseases you have had:

☐ Pneumonia	☐ Mumps	☐ Influenza	☐ Venereal Disease	☐ Genital Warts
☐ Rheumatic Fever	☐ Small Pox	☐ Pleurisy	☐ Asthma	☐ Herpes
☐ Polio	☐ Chicken Pox	☐ Arthritis	☐ Anemia	☐ Heart Disease
☐ Tuberculosis	☐ Diabetes	☐ Epilepsy / Seizures	☐ Thyroid	☐ Measles
☐ Whooping Cough	☐ Cancer	☐ Mental Disorder	☐ Eczema	☐ German Measles / Rubella

11. Have you been treated for any other condition not covered in the above questionnaire (describe)? _____

_____

When? _____

12. SLEEP HABITS: Average hours per night: _____

13. BOWEL MOVEMENTS: Times per week: _____

14. DIET

Please describe your diet by indicating how many times per day / week / month you have the following:

Eggs	_____ times per	_____	Alcohol	_____ times per	_____
Milk products	_____ times per	_____	Chocolate	_____ times per	_____
Wheat products:			Other sweets	_____ times per	_____
Pasta	_____ times per	_____	Soft drinks	_____ times per	_____
Bread	_____ times per	_____	White flour products	_____ times per	_____
Rolls / Muffins	_____ times per	_____	Water	_____ times per	_____
Red meat	_____ times per	_____	Fried food	_____ times per	_____
Chicken	_____ times per	_____	Cigarettes	_____ times per	_____
Fish	_____ times per	_____	Grains	_____ times per	_____
Fresh vegetables	_____ times per	_____	Foods craved:	_____	
Fresh fruit	_____ times per	_____	Meals per day:	_____	
Salad	_____ times per	_____			
Coffee	_____ times per	_____			
Tea (caffeinated)	_____ times per	_____			

15. EXERCISE

Type _____ Frequency _____ Times (day or week)

Type _____ Frequency _____ Times (day or week)

Type _____ Frequency _____ Times (day or week)

Patient's Signature X _____ Date _____