BACK TO HEALTH
CHIROPRACTIC

CONFIDENTIAL PATIENT HEALTH HISTORY

Today's Date: _____ Patient #: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: ____ ☐ Male ☐ Female

Address: _____ City: _____State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____Cell Phone:_____

Marital Status: ☐ Single ☐Married Spouse's Name: _____

Work Phone: _____Number of Children & Ages: _____

Employer: _____ Occupation: _____

Name & Number of Emergency Contact: _____ Relationship: _____

Whom may we thank for referring you to this office? _____

Are you pregnant? ☐ N ☐ Y Due Date:_____

If **job related**, have you reported this accident to your employer? ☐ **N** ☐ **Y,** _____**Date of injury**

If related to a **car accident**, have you reported this injury to the insurance? ☐ **N** ☐ **Y,** _____**Date occurred**

FINANCIAL INFORMATION – *Please allow our staff to photocopy your insurance card.*

☐ Insurance ☐ Self-Pay (cash) ☐ Personal/Auto ☐ Other (please explain) _____

Primary Insurance

Name: _____

Relation to Insured: Self/Spouse/Parent/Child/Other

Other than self:
Insured's Name: _____

Date of Birth: _____ ☐ M ☐ F

Social Security #: _____

Secondary Insurance

Name: _____

Relation to Insured: Self/Spouse/Parent/Child/Other

Other than self:
Insured's Name: _____

Date of Birth: _____ ☐ M ☐ F

Social Security #: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to our office today:

First: _____How Long? _____ Second: _____ How Long? _____

Third: _____How Long? _____ Fourth: _____How Long? _____

Current Level of Pain?	Minimal: 1 2 3	Slight: 4 5 6	Moderate: 7 8 9	Severe: 10
At its worst, pain is?	Minimal: 1 2 3	Slight: 4 5 6	Moderate: 7 8 9	Severe: 10

Describe how your *primary complaint* began. What caused it or what were you doing when you noticed the pain?

_____

_____

_____

Is the complaint/pain? Dull Achy Burning Sharp Numb Stiff & Sore Stabbing

Does the complaint radiate/shoot to any areas of your body? No / Yes ***If Yes, circle where below:***

Head – Base of Skull / Forehead / Temples R / L / Both *Leg* – Hip / Thigh-Knee/ Foot-Toes R / L / Both

Arm – Shoulder / Elbow/ Hands-fingers R / L / Both *Other Area*: _____

What makes your symptoms feel better? Ice Heat Rest Movement Stretching Medication
Other: _____

What makes your symptoms feel worse? Sit Stand Lying Walking Overuse Sleep

Other:_____

Does Pain? Come & Go? Or Constant? -- *on & off during the day / on & off during the week*

Who have you seen for this condition? Medical Doctor Physical Therapist Acupuncturist
Surgeon Massage Other:_____

Have you seen a Chiropractor before? ☐ N ☐ Y If yes, who & when?_____

What were the results? ☐ Favorable ☐ Unfavorable → please explain:

_____

Have you had any other injury(s) to your spine, minor or major? List even if it was over 20 years ago:
car accidents / slips & falls / sports injuries / military / police / fire background / hospitalizations / etc.

_____

_____

_____

Have you had previous diagnostic tests? X-Ray MRI Nerve Conduction E.M.G Other: _____

Do you have copies of x-ray, MRI, or any reports? No Yes ***If yes, please give to doctor for review***

Have you had? Spinal Epidural Spine Surgery If yes, do you know what level of Neck or Low back:

C1-2 C2-3 C3-4 C4-5 C5-6 C6-7 C7-T1 L1-2 L2-3 L3-4 L4-5 L5-S1 Left Hip Right Hip

If no, has any doctor ever suggested? Spinal Epidural Spine Surgery

What else have you tried that hasn't helped? _____

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following conditions: None ☐

Tumors ☐ Cancer ☐ Heart Attack ☐ Diabetes ☐ Autoimmune ☐ Rheumatoid Arthritis ☐ Fractures ☐

Osteoarthritis ☐ Cerebral-Vascular ☐ Any other medically diagnosed conditions? _____

_____

*Indicate if you have ever been diagnosed with any of the following: ***P*** for in the **Past**, ***C*** for **Currently***
(Circle the one that applies - ie: Diarrhea/Constipation)

__ Recent Weight Change	__ Sinus/Allergies	__ Difficulty Sleeping	__ Diarrhea / Constipation
__ Fever	__ Ringing/Buzzing in Ears	__ Chest Pain	__ Blood in Stool / Urine
__ Fatigue	__ Pain behind Eyes	__ Shortness of Breath	__ Nausea / Vomiting
__ Sciatica L/R	__ Blurred Vision	__ Heart Palp/Murmur	__ Abdominal Pain
__ Hip Pain L/R	__ Ear infections	__ Cold Sweats/Hot Flash	__ Frequent Urination
__ Headaches/Migraines	__ Loss of Taste/Smell	__ Asthma / Wheezing	__ Urinary Tract Infection
__ Dizziness/ light-headed	__ Faint/Loss of Balance	__ Upper Resp. Infection	__Cramping/Irregular Periods
__ Pain/Numb Arms-Legs	__ Thyroid Problems	__ Heart Burn/Indigestion	__ Difficulty Getting Pregnant
__ Tingling/Weak Arm-Leg	__ Depression	__ Ulcers/Acid Reflux	__ Impotence
__ Weak muscles or Joints	__ Stroke	__ Loss of Appetite	__ Nervousness/Anxiety
__ Stiff / Swollen Joints	__ Convulsions/Seizures	__ Memory Loss/ Confusion	__ Mood Swings/Irritable

List any surgical operations and year they were performed: *(type / year / right or left)*

_____

_____

List any broken bones / fractures or dislocations you have had: *(right or left / year)*

_____

_____

List any medications (over-the-counter & prescription): *Did you bring a list? May we make a copy?* ☐ None

_____

List any vitamins or supplements you are taking: *Did you bring a list? May we make a copy?* ☐ None

_____

FAMILY HISTORY

Ie: Relationship: Maternal Grandmother

☐ Heart Disease Relationship: _____

☐ Stroke Relationship: _____

☐ Cancer Relationship: _____

☐ Autoimmune Relationship: _____

Type of Cancer or Autoimmune: _____

Any other family history that might be relevant? _____

SOCIAL HISTORY

Do you smoke? ☐No ☐Yes _____packs/day

Do you drink coffee? ☐No ☐Yes _____cups/day

Do you drink alcohol? ☐No ☐Yes _____drinks/day

Do you exercise regularly? ☐No ☐Yes

Do you wear Heel Lifts: ☐No ☐Yes

Do you do recreational drugs? ☐No ☐Yes

HOW DOES THIS AFFECT YOUR ACTIVITIES OF DAILY LIVING? CIRCLE ALL THAT APPLY

Family and Home Life

Getting Ready Wake up in Pain Driving Errands Sleeping House work/Projects

Going to the Bathroom Playing with Children Yard Work Intimacy/ Spending Time with Partner

Recreation/Social

Sports Workout Hobbies Social Life

Work

Sitting Standing Bending Lifting Driving Walking

Computer Work Missed Time from Work Placed on Disability

What is the #1 thing you would like to be able to do again if you didn't have this pain? _____

Do you feel weakness in your? Neck Shoulder Arm Forearm Wrist Fingers

Do you feel weakness in your? Back Hips Thighs Knees Calves Feet

Do you feel loss of sensation in your? Neck Shoulder Arm Forearm Wrist Fingers

Do you feel loss of sensation in your? Back Hips Thighs Knees Calves Feet

Does this condition cause? Foot Drop Bladder Control Issues Sexual Dysfunction

What concerns do you have about treatment in our office for your condition? _____

_____

What is your level of commitment to improving your condition if we determine we can help you?

Not Committed: 1 2 3 4 Not Sure: 5 6 7 8 Committed: 9 10

Is there anything else you would like the doctor to know? _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services. I clearly understand and agree that all services rendered are ultimately my responsible for payment.

_____ _____ - _____ - _____

Patient or Guardian Signature Date Completed

_____ _____ - _____ - _____

Doctor's Signature Date Form Reviewed