

## Reason For Visit

Please describe the pain & its location: \_\_\_\_\_

The reason for this visit is a result of (Please circle): work, sports, auto, trauma or chronic.

(Explain what happened): \_\_\_\_\_

Pain Level (Please circle):    0    1    2    3    4    5    6    7    8    9    10

Type of pain: Sharp Stabbing Burning Achy Dull Stiff Sore

When did this condition begin? \_\_\_\_/\_\_\_\_/\_\_\_\_.

Is the condition getting worse (Please check one)?  Yes  No

Is the condition (Please check one)?  Constant  Comes and goes

What makes it Better (Please circle)? Ice Heat Rest Movement Stretching OTC Other: \_\_\_\_\_

What makes it Worse (Please circle)? Sitting Standing Walking Lying Down Lifting Bending Sleep Overuse  
Other: \_\_\_\_\_

Is the condition interfering with your (Please circle): work, sleep, or daily routine.

If so, please explain: \_\_\_\_\_

Have you seen another doctor for this condition?  Yes  No

If so, Who? \_\_\_\_\_

Have you ever been treated by a Chiropractic Doctor before?  Yes  No

If so, please explain: \_\_\_\_\_

Have you been treated for any other health condition in the last year?  Yes  No

If yes, explain: \_\_\_\_\_

### Family History:

#### Yourself

#### Relative

Heart

Arthritis

Cancer

Diabetes

Major Surgeries

Allergies

Other:

Accident History: \_\_\_\_\_

Medications: \_\_\_\_\_

Who is your family doctor? \_\_\_\_\_ Where? \_\_\_\_\_

May we contact him/her concerning your care?  Yes  No

## About You

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name you wish to be called in our office: \_\_\_\_\_

Home address: \_\_\_\_\_  
CITY STATE ZIP

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Cell phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Your occupation? \_\_\_\_\_

Employer or Company Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

In Case of Emergency, contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

How do you plan to take care of your charges today? Cash Check Credit Card

## Insurance Information

Insurance #1 \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's SSN: \_\_\_\_\_

Relation to patient: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insurance #2 \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's SSN: \_\_\_\_\_

Relation to patient: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer: \_\_\_\_\_

# Health History Questionnaire

Instructions: Indicate if you currently (C) have any of these conditions, or if you have ever had any of these in the past (P).

C = Current P = Past

### MUSCULOSKELETAL SYSTEM

- C  P Low back pain
- C  P Mid back pain
- C  P Pain between shoulders
- C  P Neck pain
- C  P Arm problems
- C  P Leg problems
- C  P Swollen joints
- C  P Painful joints
- C  P Stiff joints
- C  P Sore muscles
- C  P Weak muscles
- C  P Walking problems
- C  P Spasms
- C  P Broken bones
- C  P Shoulder pain

### GASTRO-INTESTINAL SYSTEM

- C  P Poor appetite
- C  P Excessive hunger
- C  P Difficult chewing
- C  P Difficult swallowing
- C  P Excessive thirst
- C  P Nausea
- C  P Vomiting blood
- C  P Abdominal pain
- C  P Diarrhea
- C  P Constipation
- C  P Black stool
- C  P Bloody stool
- C  P Hemorrhoids
- C  P Liver trouble
- C  P Gall Bladder problems
- C  P Weight trouble

### GENITO-URINARY SYSTEM

- C  P Bladder trouble
- C  P Excessive urination
- C  P Scanty urination
- C  P Painful urination
- C  P Discolored urine

### NERVOUS SYSTEM

- C  P Numbness
- C  P Loss of Feeling
- C  P Paralysis
- C  P Dizziness
- C  P Fainting
- C  P Headaches
- C  P Muscle jerking
- C  P Convulsions
- C  P Forgetfulness
- C  P Confusion
- C  P Depression
- C  P Insomnia

### CARDIO-VASCULAR RESPIRATORY SYSTEMS

- C  P Chest pain
- C  P Pain over heart
- C  P Difficulty breathing
- C  P Shortness of breath
- C  P Persistent cough
- C  P Coughing phlegm
- C  P Coughing blood
- C  P Rapid heartbeat
- C  P Blood pressure problems
- C  P Heart problems
- C  P Lung problems
- C  P Varicose veins

### FEMALE

ARE YOU PREGNANT?  
 YES  NO

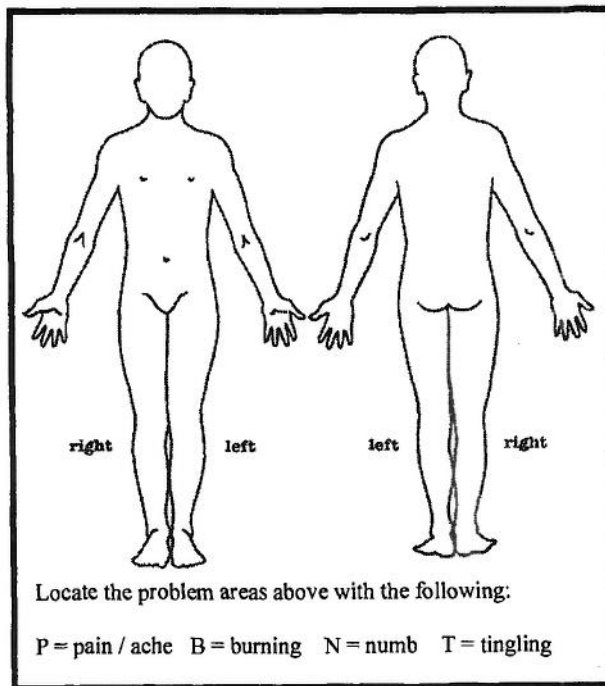
- C  P Vaginal discharge
- C  P Vaginal bleeding
- C  P Vaginal pain
- C  P Breast pain
- C  P Lumps on the breast

### EYE, EARS, NOSE AND THROAT

- C  P Eye strain
- C  P Eye inflammation
- C  P Vision problems
- C  P Ear pain
- C  P Ear noises
- C  P Ear discharge
- C  P Hearing loss
- C  P Nose pain
- C  P Nose bleeding
- C  P Nose discharge
- C  P Difficulty breathing through nose
- C  P Sore gums
- C  P Dental problems
- C  P Sore mouth
- C  P Sore throat
- C  P Hoarseness
- C  P Difficult speech
- C  P Sinus
- C  P Allergy
- C  P Jaw Pain

### HABITS

- C  P Cigarettes
- C  P Alcohol Abuse
- C  P Coffee or Tea
- C  P Drug Abuse
- C  P \_\_\_\_\_



Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Accepted?  Yes  No    Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_