# Patient History (Please Print)

Date: _____

Name: _____ Email: _____
Phone: (Home) _____ (Mobile) _____ (Work) _____
Address: _____ City: _____ Zip: _____
Birth Date: ____/____/_____ □ Male □ Female Spouse/Parent Name: _____
# of Children: _____ □ Married □ Single □ Divorced □ Widowed
Are you Pregnant**?** □ **YES** □ **NO** **Due Date:**_____
Occupation: _____ Social Security #: _____

How were you referred to our office? _____
If from the internet, name of search engine and key words used: _____
Have you ever had Chiropractic Care before? _____ If yes, when? _____

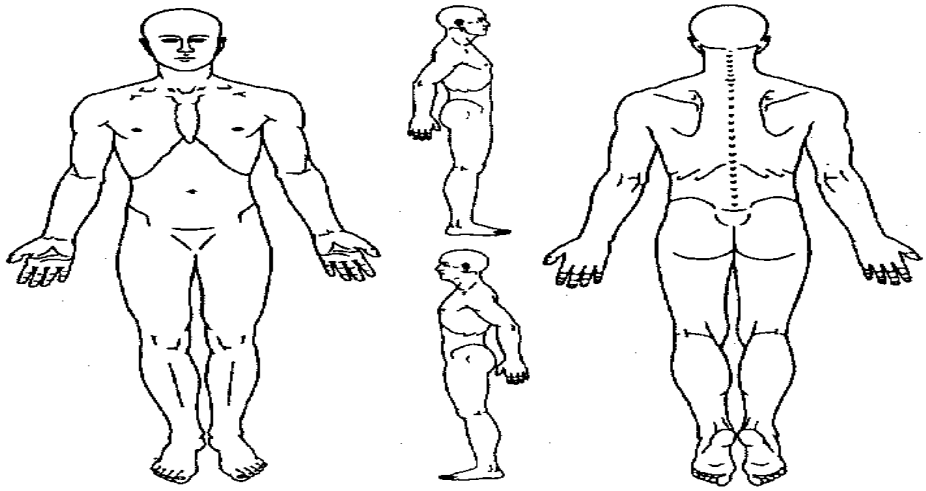
**List your chief complaints in order of severity; Check all those that describe your condition:**

Complaint 1: _____ For How Long? _____
What originally caused this problem? _____
**Feels Like:**
□ Sharp □ Throbbing □ Shooting □ Cramps □ Stiffness □ Dull Ache □ Numb/Tingling
□ Burning □ Other: _____
**Bothers Me:**
□ Constant (100%) □ Frequent (50%-75%) □ Intermittent (25%-50%) □ Occasional (1%-25%)
**It Has Been:**
□ Getting Worse □ Staying Same □ Getting Better
**Pain Scale: (0=No Pain – 10=Severe Pain)**
□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
**During The Day It Is:**
□ Worse in the AM □ Stays the same throughout the day □ Worse in the PM
**The Following Increases Pain:**
□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____
**The Following Decreases Pain:**
□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____
**Does The Pain Travel/Radiate? :**
□ Yes □ No If yes, where_____ to _____

Complaint 2: _____ For How Long? _____
What originally caused this problem? _____
**Feels Like:**
□ Sharp □ Throbbing □ Shooting □ Cramps □ Stiffness □ Dull Ache □ Numb/Tingling
□ Burning □ Other: _____
**Bothers Me:**
□ Constant (100%) □ Frequent (50%-75%) □ Intermittent (25%-50%) □ Occasional (1%-25%)
**It Has Been:**
□ Getting Worse □ Staying Same □ Getting Better
**Pain Scale: (0=No Pain – 10=Severe Pain)**
□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
**During The Day It Is:**
□ Worse in the AM □ Stays the same throughout the day □ Worse in the PM
**The Following Increases Pain:**
□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____
**The Following Decreases Pain:**
□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____
**Does The Pain Travel/Radiate? :**
□ Yes □ No If yes, where_____ to _____

**Initials:**_____

**Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels. Include all affected areas.**



**Does your condition interfere with:**

| | | | | |
|---|---|---|---|---|
| Work | □ NO | □ MILD | □ MODERATE | □ SEVERE |
| Sleep | □ NO | □ MILD | □ MODERATE | □ SEVERE |
| Daily Routine | □ NO | □ MILD | □ MODERATE | □ SEVERE |
| Recreation | □ NO | □ MILD | □ MODERATE | □ SEVERE |

**Does your condition interfere with any of the following:**

| | | |
|---|---|---|
| □ Computer Use | □ Cleaning | □ Shopping |
| □ Sports | □ Cooking | □ Gardening |
| □ Reading | □ Watching Kids | □ School |
| □ Exercise | □ Yard Work | □ Self Care |
| □ Vacuuming | □ Driving | □ Other: _____ |
| □ Social Life | □ Relationship | |

**List of Previous Hospital Stays/Surgeries (Month/Year):**

_____

_____

_____

**List of Any Falls/Traumas (Month/Year):**

_____

_____

**Past Auto Accidents Minor or Major (Month/Year):**

_____

_____

**Past Sports Injuries Minor or Major (Month/Year):**

_____

_____

**Patient's Signature:** _____ **Date:** _____

***Present your Insurance card to the front desk for a complimentary review of benefits****