PERSONAL HISTORY FORM

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

Name ______________________________ S.S.# ____________________

Address ____

City ______________________ State __________ Zip ______________

Home phone ____________________ Business phone ______________

Cell phone ____________________ e-mail address ________________

Gender: ☐ Male ☐ Female Birth Date ________ Age _____ Spouse/Partner ____________

Employer ______________________ Occupation __________________

Employment address ____

In case of emergency contact ____________________ Phone ____________

How did you hear about our clinic? ______________________________

Is your pain the result of a motor vehicle accident?	☐ YES	☐ NO
If so, have you filed a legal suit?	☐ YES	☐ NO
Is your pain the result of a work related injury?	☐ YES	☐ NO
If so, have you filed a worker's compensation claim?	☐ YES	☐ NO

How would you describe your chief complaint at this time? ______________________________

Is there any numbness, tingling or weakness present in your hands or feet? ______________________________

When did it start? (Include month and year, day if known) ______________________________

What makes your symptoms worse? ______________________________

What makes your symptoms better? ______________________________

Patient Name ______________________ Date ______________

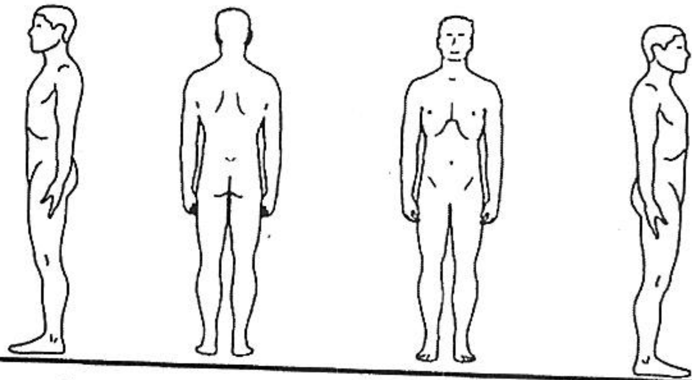
Are your symptoms: ☐ Intermittent ☐ Constant **Are they worse:** ☐ AM ☐ PM ☐ Same

Any other times of the day or week your pain worse? ______________________

Have you had this problem in the past? ☐ YES ☐ NO If YES, how often? ______________

Location & Intensity (0=no symptoms; 10=severe pain) **Please mark areas of pain or discomfort:**

Neck ______	/10
Upper Back ______	/10
Mid-Back ______	/10
Lower Back ______	/10
Shoulder R / L ______	/10
Leg R / L ______	/10
Other: ______	/10



Have you seen any other doctors for this condition? ☐ YES ☐ NO If yes, **please list:**

Doctor #1 ______________ X-Ray? ______ Date of 1st visit: ______

Medications/Therapy prescribed: ______________

Doctor #2 ______________ X-Ray? ______ Date of 1st visit: ______

Medications/Therapy prescribed: ______________

Doctor #3 ______________ X-Ray? ______ Date of 1st visit: ______

Medications/Therapy prescribed: ______________

Have you had previous chiropractic care? ☐ YES ☐ NO

If YES, when was the last time you were adjusted? ______________

Doctor's Notes:

Patient Name ______________________________ Date ____________

Do you exercise regularly? ☐ YES ☐ NO **If yes, how many times per week?** __________

If yes, what activities? ______________________________

When you engage in the physical activity noted above, **what is the average duration of activity?**

☐ Less than 10 minutes ☐ 10 – 20 mins ☐ 20 – 30 mins ☐ 30 – 60 mins ☐ over 60 mins

When you engage in the physical activity noted above, **what do you feel the level of effort is?** __________

____

At work, how many days per week do you engage in tasks that are intense enough to cause sweating and a rapid heart rate? ______________________________

Please rate your level of fitness (0 = very poor, 5 = average, 10 = excellent) __________

Do you have a past history of injuries involving: (dates)

ankles __________ knees __________ hips __________

wrists __________ elbows __________ shoulders __________

Please list any other accidents, injuries, surgeries and hospitalizations you have had.

______________________________ Date or Age __________

______________________________ Date or Age __________

______________________________ Date or Age __________

Have you had X-rays taken of your spine within the last 10 years? ☐ YES ☐ NO

If yes, location and date of X-rays ______________________________

Location and date of MRIs ______________________________

MEN: Date of last prostate exam __________ Date of last colon exam __________

Any unusual findings? ______________________________

WOMEN: Date of last pap smear __________ Date of last mammogram __________

Any unusual findings? ______________________________

Do you have breast implants? ☐ YES ☐ NO Date implanted/removed __________

Patient Name ______________________________ Date ______________

PLEASE CHECK ANY OF THE FOLLOWING YOU ARE CURRENTLY EXPERIENCING

HEAD
_____ Headache
_____ Loss of balance
_____ Dizziness
_____ Deafness
_____ Ringing in ear(s)
_____ Jaw pain
_____ Fainting
_____ Eye Pain
_____ Failing Vision
_____ Frequent nosebleeds
_____ Sinus Infection(s)

CHEST
_____ Chest Pain
_____ Difficulty breathing
_____ Asthma

ABDOMEN
_____ Difficult digestion
_____ Abdominal cramps
_____ Diarrhea
_____ Constipation
_____ Nausea
_____ Change in urinary function
_____ Change in bowel function
_____ Hemorrhoids

OTHER
_____ Fatigue
_____ Loss of sleep/insomnia
_____ Nervousness
_____ Fever
_____ Change in menstrual cycle
_____ Hot flashes

Do you or other family members have a history of any of the following?

Arthritis	☐ Family member	☐ Self	☐ Medications	______________
Asthma	☐ Family member	☐ Self	☐ Medications	______________
Autoimmune	☐ Family member	☐ Self	☐ Medications	______________
Cancer	☐ Family member	☐ Self	☐ Medications	______________
Depression	☐ Family member	☐ Self	☐ Medications	______________
Diabetes	☐ Family member	☐ Self	☐ Medications	______________
Fibromyalgia	☐ Family member	☐ Self	☐ Medications	______________
Heart Disease	☐ Family member	☐ Self	☐ Medications	______________
High Cholesterol	☐ Family member	☐ Self	☐ Medications	______________
Hypertension	☐ Family member	☐ Self	☐ Medications	______________
Kidney Disease	☐ Family member	☐ Self	☐ Medications	______________
Mental Illness	☐ Family member	☐ Self	☐ Medications	______________
Migraines	☐ Family member	☐ Self	☐ Medications	______________
Stroke/TIA	☐ Family member	☐ Self	☐ Medications	______________

PLEASE GIVE DATES FOR ANY OF THE FOLLOWING YOU HAVE HAD PREVIOUSLY:

_____ Alcoholism
_____ Allergies
_____ Anemia
_____ Arteriosclerosis

_____ Appendectomy
_____ Chemical dependency
_____ Chicken Pox
_____ Colitis

_____ Concussion/head injury
_____ Diphtheria
_____ Eating disorder
_____ Eczema

Patient Name ______________________________ Date ____________

______ Emphysema
______ Epilepsy
______ Fractures
______ Glaucoma
______ Goiter
______ Gout
______ Gall bladder problems
______ HIV/AIDS
______ Hepatitis
______ Herniated disc
______ Irritable Bowel Syndrome

______ Kidney stone or infection
______ Liver problems
______ Measles
______ Mumps
______ Malaria
______ Multiple sclerosis
______ Numbness in hands/feet
______ Osteoporosis
______ Pacemaker
______ Pinched nerve
______ Polio
______ Pneumonia

______ Prostate problems
______ Pleurisy
______ Scarlet Fever
______ Scoliosis
______ Small Pox
______ Tuberculosis
______ Thyroid trouble
______ Ulcers
______ Whooping cough
______ Weakness in arms or legs

Please list any allergies that you have ______________________________

____

PLEASE MARK ALL THAT APPLY:

______ Avoid dairy
______ Avoid wheat
______ Avoid corn
______ Avoid sugar
______ Avoid night snacks
______ Avoid nuts

______ Drink alcohol ______ per week
______ History of smoking ☐ current ☐ past
______ Recreational drugs ______________
______ Caffeinated drinks ________ cups/day
______ Soda __________ cans/day
______ Anabolic steroids / EPO / Other

Any other health conditions you currently have? (Please list condition and any medications)

____
____
____
____

Patient Name ______________________________ Date ______________

What medications, vitamins, supplements, herbs do you take?

Name	Reason

Do you have any other concerns?______________________________

____

____

____

____

Patient Signature **Date**

Doctor's Notes: