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 major complaints. No symptom is insignificant. The more you tell us the more we will be able to help you achieve your health goals.

Date: _____ **Name:** First: _____ Last: _____ Nick Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SS #: _____ Birth date: _____ Age: _____ Sex: M F Height _____ Weight: _____

Home phone: _____ Business phone: _____ Cel: _____
Check one: Married □ Widowed □ Single □ Divorced □ Separated □

Business/Employer: _____ Type of Work: _____

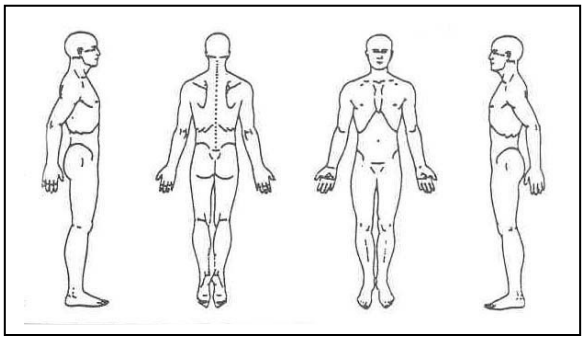
Spouses Name: _____Number of Children_____

Referred to this office by: _____ Driver's license # _____
Name and address of nearest relative not living with you: _____
Are you / have you been disabled from work? _____
Current medications: **Tranquilizers** □ **Pain killers/Muscle relaxers**□ **Blood pressure** □
Insulin □ **Aspirin / Similar** □ **Hormones** □ **Other** □
Specific drug or substance: _____
Natural remedies: Vitamins / minerals: _____
Herbs: _____
Homeopathic: _____

CURRENT HEALTH CONDITION:

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
1) Describe your pain or complaint:
Dull □ Sharp □ Ache □ Stabbing □
Deep □ Superficial □ Spasm/Tension □ Numbness □
Tingling □ Burning □ Other □
2) Radiation: Does the pain go to other parts of your 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

1) Describe your pain or complaint:

Dull □ Sharp □ Ache □ Stabbing □

Deep □ Superficial □ Spasm/Tension □ Numbness □

Tingling □ Burning □ Other □

2) Radiation: Does the pain go to other parts of your 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 □

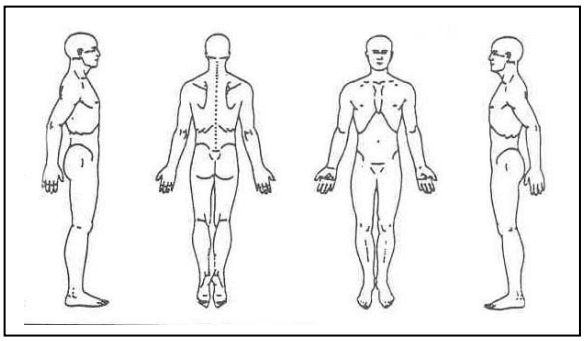
Walking □ Lifting □ Sleeping □ Heat □

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? _____

3) 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

1) Describe your pain or complaint:

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Yes □ No □ Where? _____

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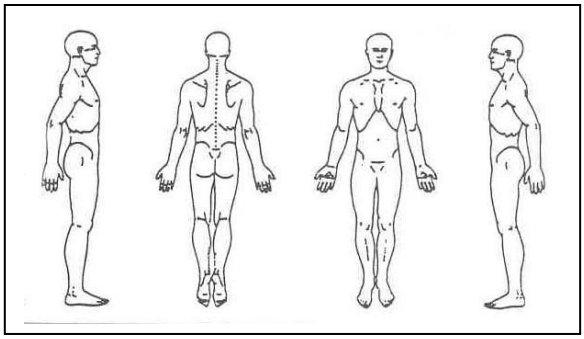

7) Other problems related to your main complaint? _____

8) What treatment have you received for this condition? _____

PAST HEALTH HISTORY:

List all surgeries 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	Mod	severe		Past	Present	Mild	Mod	severe
Low back pain	☐	☐	☐	☐	☐	Foot or ankle problems	☐	☐	☐	☐	☐
Pain between shoulders	☐	☐	☐	☐	☐	General stiffness	☐	☐	☐	☐	☐
Neck pain	☐	☐	☐	☐	☐	Fractures	☐	☐	☐	☐	☐
Arm pain or numbness or weakness	☐	☐	☐	☐	☐	Leg pain or numb or weak	☐	☐	☐	☐	☐
Joint pain or stiffness	☐	☐	☐	☐	☐	Difficult chewing or jaw clicking	☐	☐	☐	☐	☐
Walking problems	☐	☐	☐	☐	☐	Shoulder problems	☐	☐	☐	☐	☐
Muscle cramps	☐	☐	☐	☐	☐	Knee problems	☐	☐	☐	☐	☐
						Foot or ankle 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 your memory worse with stress? _____

☐ **Numbness:**
Where? _____
When did it start? _____
Frequency: occasional ☐ intermittent ☐ constant ☐

☐ **Dizziness:** past ☐ present ☐

☐ **Fainting:** past ☐ present ☐

☐ **Stress:** past ☐ present ☐

If present, what areas of your life do you consider to be stressful? _____

☐ **Depression:** past ☐ present ☐
If present, how long have you been depressed? _____
Have you ever been taken prescribed medications for depression? Yes ☐ No ☐
If yes list medications: _____
Is your current depression related to a specific situation? Yes ☐ No ☐
Is your depression Mild ☐ Moderate ☐ 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 season? _____
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? (Circle one or both) Yes □ No □
What factors do you think cause or influence this condition? _____

Skin conditions: □ past □ present □
Describe the condition: _____
List present treatments and effectiveness: _____

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

4) GENITOURINARY

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 did 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/ Infections: □ 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 problem? 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 it's effectiveness: _____

Noises in the 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 that 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 □

Gallbladder 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 is 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 you with bowel function? (List): _____
_____

Weight change: □ As and 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 affect it? _____

Gas/ Bloating after meals: Past □ Present □ If present, all meals? Yes □ No □
Certain foods? _____

8) FEMALE PROBLEMS

Your age at first period: _____ Most recent period began, date: _____
How many days do you flow? _____ 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 (premenstrual 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

Prostrate problems: □ Past □ Present □
If present, describe symptoms: _____
List any treatment and it's 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: _____ When did this begin? _____
List any treatment and its effectiveness: _____

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

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) OTHER

Have you ever 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	Day /week/ month	**ALCOHOL**	_____	Times per	Day/Week/ Month
MILK PRODUCTS	_____	Times per	Day /week/ month	**CHOCOLATE**	_____	Times per	Day /week/ month
WHEAT PRODUCTS	_____	Times per	Day /week/ month	**SWEETS**	_____	Times per	Day /week/ month
PASTA	_____	Times per	Day /week/ month	**SOFT DRINKS**	_____	Times per	Day /week/ month
BREAD	_____	Times per	Day /week/ month	**WHITE FLOUR PRODUCTS**	_____	Times per	Day /week/ month
ROLLS/ MUFFINS	_____	Times per	Day /week/ month	**WATER**	_____	Times per	Day /week/ month
RED MEAT	_____	Times per	Day /week/ month	**FRIED FOODS**	_____	Times per	Day /week/ month
CHICKEN	_____	Times per	Day /week/ month	**CIGARETTES**	_____	Times per	Day /week/ month
FISH	_____	Times per	Day /week/ month	**GRAINS**	_____	Times per	Day /week/ month
FRESH VEGETABLES	_____	Times per	Day /week/ month	**MARGARINE**	_____	Times per	Day /week/ month
FRESH FRUIT	_____	Times per	Day /week/ month	**YOGURTS**	_____	Times per	Day /week/ month
SALAD	_____	Times per	Day /week/ month	**FAST FOODS**	_____	Times per	Day /week/ month
COFFEE	_____	Times per	Day /week/ month	**CHIPS & DIP**	_____	Times per	Day /week/ month
T EA (DECAF)	_____	Times per	Day /week/ month	**CANDIES**	_____	Times per	Day /week/ month

Foods craved: _____ **Meals per day:** _____

_____

15) Exercise

Type _____ Frequency _____ Times (day or week) _____ Enjoyment level (high)(med)(low)
Type _____ Frequency _____ Times (day or week) _____ Enjoyment level (high)(med)(low)
Type _____ Frequency _____ Times (day or week) _____ Enjoyment level (high)(med)(low)
Type _____ Frequency _____ Times (day or week) _____ Enjoyment level (high)(med)(low)
Type _____ Frequency _____ Times (day or week) _____ Enjoyment level (high)(med)(low)
Type _____ Frequency _____ Times (day or week) _____ Enjoyment level (high)(med)(low)

I understand and agree that my health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that If I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

Patient's signature X_____ Date _____

Guardian or Spouse's
Signature Authorizing care _____ Date _____