Name: ____ Date: _______________________

Reason for today's visit: ____

Date the symptoms began: ________________________

Are your symptoms due to: ☐ Auto accident ☐ Work ☐ Sports ☐ Other _________________________

Explain: ____

Have you ever had similar symptoms or similar injuries before? ☐ No ☐ Yes If Yes, When?

____

Other health care providers seen for these symptoms and when: _______________________________

In what way does this interfere with your normal activities and / or work? _______________________

Have you lost time from work? ☐ No ☐ Yes Dates: _____________________________________

When are you most uncomfortable? ☐ Morning ☐ Afternoon ☐ Evening ☐ During the night ☐ Other ___________

What activities or positions make your symptoms worse?

☐ Sitting ☐ Standing ☐ Lying Down ☐ Bending ☐ Lifting ☐ Walking ☐ Other ______________

What makes your symptoms feel better? ____

Describe the **quality(s)** of your symptoms: ☐ Dull ☐ Sharp ☐ Throbbing ☐ Ache ☐ Burning ☐ Numbness ☐ Tingling

How often are your symptoms: ☐ Occasionally (0 – 25% of the time) ☐ Intermittently (26 – 50% of the time)

☐ Frequently (51 – 75% of the time) ☐ Constantly (76 –100% of the time)

EXERCISE ACTIVITY	**WORK ACTIVITY**	**TOBACCO USE**	**ALCOHOL USE**	**OTHER**
☐ None	☐ Sitting	☐ Never	☐ Never	☐ Soda
☐ 1 per week	☐ Standing	☐ Currently	☐ Occasionally	☐ Coffee
☐ 2-3 per week	☐ Light labor	____ Packs per day	☐ Moderately	
☐ Daily	☐ Heavy labor	☐ Previous, but quit	☐ Daily	

List **all** medications and for what conditions:

______________________________ ______________________________

______________________________ ______________________________

List any allergies to medications, foods or other:

______________________________ ______________________________

______________________________ ______________________________

List all injuries, serious illnesses and surgeries. Include date - month and year

______________________________ ______________________________

______________________________ ______________________________

List recent X-Rays, lab or other tests. Include Doctor / Facility and date – month and year

______________________________ ______________________________

______________________________ ______________________________

Previous Chiropractic care: ☐ Yes ☐ No Doctor's name and approximate date of last visit: ____________________

PATIENT HISTORY QUESTIONNAIRE	PAGE – 2	**RN:** __________

Name: ____ Date: _________________________________

Please indicate with a "√ " the appropriate box for any of the following symptoms, which you now have or have had previously.
COMPLETING THIS FORM WILL HELP US DETERMINE THE BEST TREATMENT OPTIONS TO HELP YOU.
C = CURRENTLY EXPERIENCING P = PREVIOUSLY EXPERIENCING

C	P		C	P		C	P	
		MUSCULOSKELETAL			**NERVOUS SYSTEM**			**CARDIOVASCULAR**
		Headaches			Numbness			Heart attack
		Neck Pain			Cold /tingling extremities			High blood pressure
		Upper back pain			Paralysis			Low blood pressure
		Shoulder pain L R			Dizziness			Irregular heartbeat
		Arm pain L R			Fainting			Stroke
		Arm numbness L R			Depression			Pacemaker
		Hand pain L R			Forgetfulness			Aneurysm
		Hand numbness L R			Fatigue			Swollen ankles
		Mid back pain			Stress			**GASTROINTESTINAL**
		Chest pain			Loss of Sleep			Painful / excessive urination
		Low back pain			Convulsions			Liver / gall bladder
		Hip pain L R			**EYE, EAR, NOSE,THROAT**			Ulcers / colitis
		Sciatic nerve pain L R			Vision problems			Nausea
		Tailbone pain			Ear infections, ear ache L R			Difficult digestion
		Leg pain L R			Hearing loss			**GENERAL**
		Leg numbness L R			Nose pain / bleeding			Nervousness/tension
		Knee or foot pain L R			Breathing problems			Fibromyalgia
		Jaw pain – TMJ L R			Allergies			Thyroid disorder
		Sore or weak muscles			Dental problems			Cancer
		Arthritis			**RESPIRATORY**			Diabetes
		Scoliosis			Difficulty breathing			Abnormal weight gain / loss
		Walking problems			Asthma			AIDS/HIV
		Fractured bones			Chronic cough			Bed wetting
		Metal screws/implants			Chest pain			Chronic fatigue

HEADACHE frequency and duration

A. How often do you have headaches:

- ☐ Every day
- ☐ 3 - 5 times per week
- ☐ 1 - 2 times per week
- ☐ 1 - 2 times per month
- ☐ Rarely
- ☐ Never

B. How long does your headache usually last? _______________

FOR FEMALES:

Are you pregnant? ☐ No ☐ Yes Date due: _____________

FAMILY HEALTH HISTORY

	Living	Heart Disease	Arthritis	Diabetes	Cancer	Stroke
Father	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mother	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Brother/Sister	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No