

HEALTH HISTORY/CONSULTATION

PATIENT NAME _____

DATE: _____

Briefly describe the "Chief Area of Complaint" that is concerning you most.

Does your Pain Radiate? (travel) No Yes _____

About when did this problem start? _____ since then,

is it: About the same Getting Better Getting Worse _____

What do you think caused your problem? _____

Type of Pain? Sharp Dull Throbbing Aching Burning Stiffness

Numbness (Where) _____ Tingling (Where) _____

Have you had this problem before? No Yes If yes, when _____

How Often _____

Symptoms interfere with: Work Sleep Walking Sitting Hobbies Leisure

Other Doctors seen for this problem: Chiropractor Medical Doctor Other

What Makes you feel better? _____

What aggravates your condition? Bending Reaching Turning Head Sitting

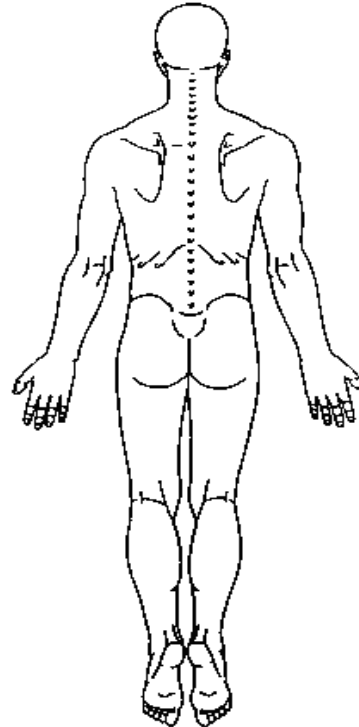
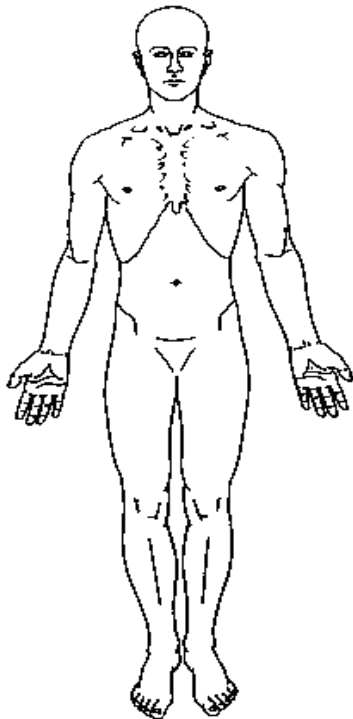
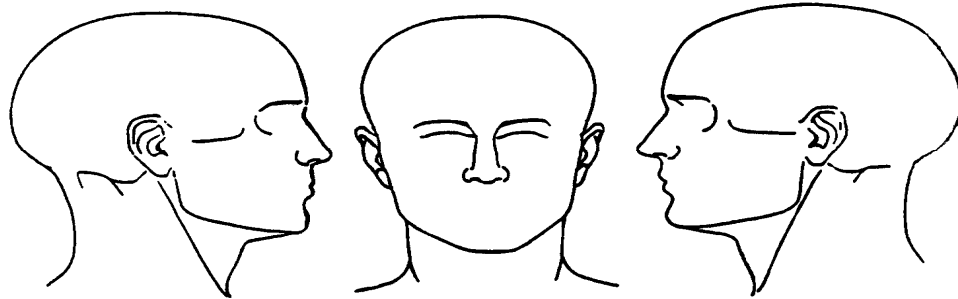
Coughing Sneezing Lying down Standing Bowel Movements Other

Last Name: _____

First Name: _____

Please draw the location of your symptoms on the body diagram below and mark your current level of pain **0 (no pain) – 10 (worst pain possible)**

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
####	=====	OOOOO	///////	XXXXX



	SYMPTOM	PAIN LEVEL (0-10)
1		
2		
3		
4		
5		

Date: _____

PAST MEDICAL HISTORY

Please check **all** boxes that apply to you, **past and/or present**, even if they do not seem related to your current problem. Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth.

- | | | | |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Dislocated Joints | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Disc Problems |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Cancer/Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Black/Bloody Stool |

Have you ever been hospitalized or had any surgery?

REASON

DATE

Have you had Previous Diagnostic Testing? (MRI, CT, Ultrasound, X-Rays?) If yes please describe below

DIAGNOSTIC TEST	DATE	RESULT

PLEASE TELL US WHAT YOU ARE TAKING?

MEDICATION	REASON	DOSAGE
VITAMINS/HERBS	REASON	DOSAGE/ How long?

SOCIAL HISTORY:

How would you rate your stress levels? (0 none- 10 severe) _____

Do you Smoke? No Yes # of Packs/day? _____ How Long? _____

How many alcoholic drinks do you consume on a weekly basis? _____

How many caffeinated beverages on a daily basis? _____

Do you use recreational drugs? _____ How often? _____

Do you exercise? None Sometimes Regularly _____

Who is your Primary Care Physician/Family MD?

_____ PH: _____

Female (if applicable) I, do hereby certify that, to the best of my knowledge, I am not pregnant and the above doctor has my permission to: Perform a diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child. Date of my last menstrual period: _____

ALL PATIENT'S PLEASE SIGN HERE: *The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation. I also understand today's fees are payable at the time of service and that the x-rays remain the property of this clinic*

Signature of Patient, Parent or Guardian

Date of signature