Patient History

Name _____ Date _____
Address _____ State _____ Zip _____
Home Phone (_____)_____ Cell Phone (_____) _____
Date of Birth _____ Age _____
Referred by _____
Occupation _____
Marital Status S M D W Spouse Name _____ Cell phone: (_____)_____
Email Address _____

Please circle for each of the following: Comments if answer is Yes

1. Regarding your Birth Process:

Was the delivery long/difficult?	Y N	_____
Forceps or extraction used?	Y N	_____
C-Section?	Y N	_____
Breach?	Y N	_____
Home birth?	Y N	_____
Hospital birth?	Y N	_____

2. Growth and Development/ Childhood:

Were you breast fed?	Y N	_____
Childhood illnesses?	Y N	_____
Ear infections/ Colic/ Asthma?	Y N	_____
Attention Deficit?	Y N	_____
Antibiotics?	Y N	_____
Drugs, prescription, OTC, recreational?	Y N	_____
Surgery?	Y N	_____
Hospitalizations?	Y N	_____
Sports or other physical activities	Y N	_____
Injuries during sports?	Y N	_____
Auto accidents?	Y N	_____
Did you have other traumas?	Y N	_____
Did you ever break any bones?	Y N	_____

3. Current Health Habits:

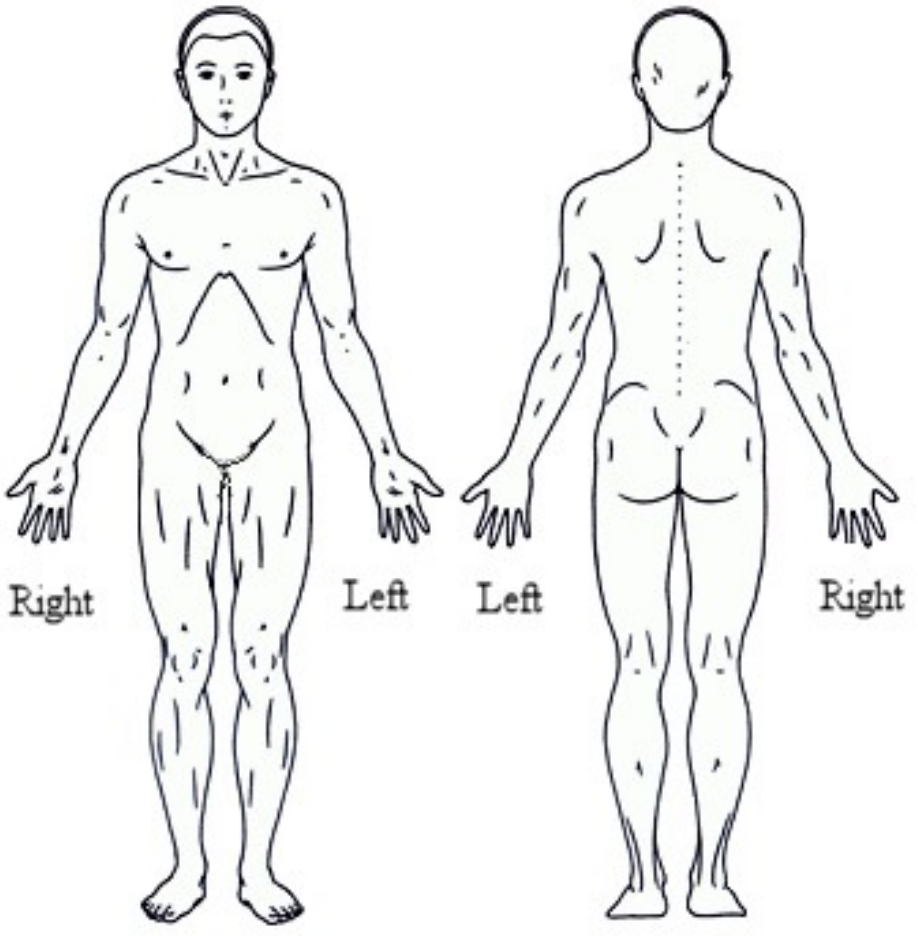
Did/do you smoke?	Y N	_____
Did/do you drink alcohol?	Y N	_____
Diet, do you eat healthy foods?	Y N	_____
Have you been in accidents/trauma?	Y N	_____
Have you had surgery?	Y N	_____
Drugs, prescription, OTC, recreational?	Y N	_____
Dental problems?	Y N	_____
Eye problems?	Y N	_____
Hearing problems?	Y N	_____
Exercise regularly?	Y N	_____
Did/do you have occupational stress?	Y N	_____
Drive? Daily time spent driving	Y N	_____
Physical stress?	Y N	_____
Emotional/Mental stress?	Y N	_____

Symptoms and Present State of Health

Present complaint/reason for seeking care in this office:
Major _____
Pain or Problem started on _____
Pains are: O Sharp O Dull/Ache O Constant O Intermittent O Other_____
Does this pain shoot, radiate, or travel in your body? Where? _____
Are you experiencing numbness or tingling in any area of your body? Where? _____
Since it began, is it: O Same O Better O Worst
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is this condition worse during certain times of the day? _____
Is this condition interfering with Work? _____ Sleep? _____ Routine? _____ Other? _____
Is this condition progressively getting worse? _____
Any physicians seen for this condition _____
Any home remedies? _____

Please circle where you are at: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain)

Using the symbols below, mark on the pictures where you feel pain.



Numbness = = =

Dull Ache OOO

Burning XXX

Sharp/Stabbing / / /

Pins, Needles + + +

Other _____ ^ ^ ^

Please mark any of the following conditions or symptoms that you have now or have experienced:

Other Symptoms:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

Are you under medical care for any condition? _____
What medications are you taking? _____
How long? _____
Have you had surgery? _____
What? _____
When? _____
What side effects have you experienced from the drugs and surgery? _____

Females Only –
Date last menstrual period began on _____
Are you possibly pregnant? _____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O