## CONFIDENTIAL HEALTH INFORMATION

All information that you provide us is strictly confidential and
will not be transferred without your permission.

**Date**
_____ `

**Name**
_____

**First name**
_____

**Address**
_____

_____

**Home Phone** _____

**Cell Phone** _____

**Email** _____

**Have you consulted a chiropractor before?**
☐ **Yes** ☐ **No**

**Gender**
☐ **Male** ☐ **female**

**Marital Status**
☐ **Single** ☐ **Married**
☐ **Divorced** ☐ **Widowed**

**Preferred method of contact?**
☐ **Cell Phone** ☐ **Home Phone**
☐ **Email**

**Emergency contact**
_____

**Cell Phone or Home Phone**
_____

**Your Occupation**
_____

1. **The symptom(s) that have prompted me to seek care today include:** _____

   _____

2. **And are the result of**
   ☐ An accident or injury
   ☐ Work ☐ Car ☐ Other _____

   ☐ A worsening long term problem
   ☐ An interest in: ☐ Wellness ☐ Other _____

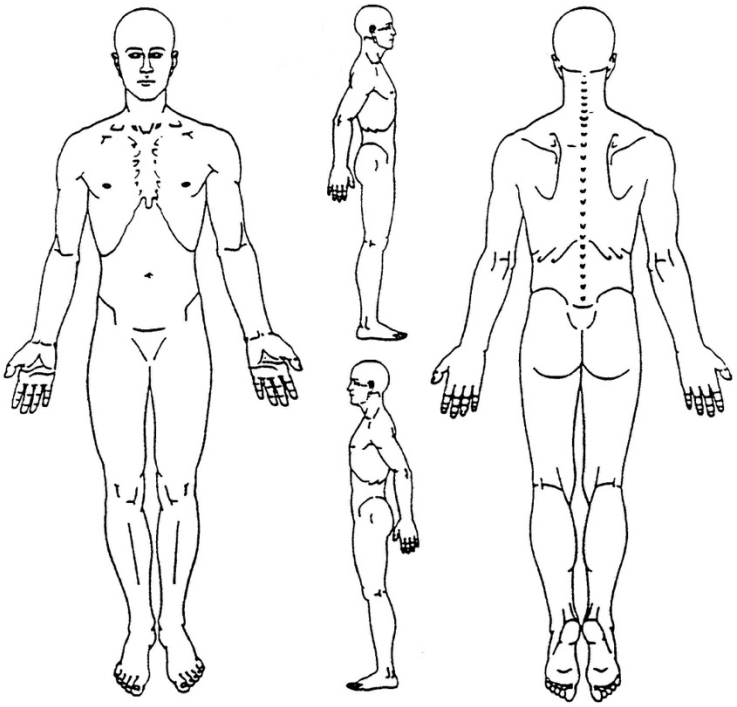
3. **Onset** (When did you first notice your current symptoms?) _____

4. **Intensity** (How extreme are your current symptoms? ) **0** O-O-O-O-O-O-O-O-O-O-O **10**
   Absent Uncomfortable Agonizing

5. **Duration and timing** (When did it start and how often do you feel it?)
   ☐ Constant ☐ Comes and goes. How often? _____

6. **Quality of symptoms** (What does it feel like?)
   ☐ Numbness ☐ Other _____
   ☐ Tingling
   ☐ Stiffness
   ☐ Dull
   ☐ Aching
   ☐ Cramps
   ☐ Nagging
   ☐ Sharp
   ☐ Burning
   ☐ Shooting
   ☐ Throbbing
   ☐ Stabbing

**7. Location** (Where does it hurt?) Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past



**8. Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

_____

**9. Aggravating or relieving factors** (What makes it better or worse, such as time of day, movements, certain activities, etc.)

_____

**10. Prior interventions** (What have you done to relieve the symptoms?)

| | | |
|---|---|---|
| ☐ Prescription medication | ☐ Surgery | ☐ Ice |
| ☐ Over-the-counter drugs | ☐ Acupuncture | ☐ Heat |
| ☐ Homeopathic remedies | ☐ Chiropractic | ☐ Other: _____ |
| ☐ Physical therapy | ☐ Massage | |

**11. How does your current condition interfere with your:**

**Work or career:** _____

**Recreational activities:** _____

**Household responsibilities:** _____

**Personal relationships :** _____

**12. Review of Systems**

Chiropractic care focusses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have**.

**A. Musculoskeletal**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Osteoporosis | ☐ | ☐ | Arthritis | ☐ | ☐ | Scoliosis | ☐ | ☐ | Neck pain | ☐ | ☐ | Back problems | ☐ | ☐ | Hip disorders |
| ☐ | ☐ | Knee injuries | ☐ | ☐ | Foot/ankle pain | ☐ | ☐ | Shoulder problems | ☐ | ☐ | Elbow /wrist pain | ☐ | ☐ | TMJ issues | ☐ | ☐ | Poor posture |

**B. Neurological**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Anxiety | ☐ | ☐ | Depression | ☐ | ☐ | Headache | ☐ | ☐ | Dizziness | ☐ | ☐ | Pins and needles | ☐ | ☐ | Numbness |

**C. Cardiovascular**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | High blood pressure | ☐ | ☐ | Low blood pressure | ☐ | ☐ | High cholesterol | ☐ | ☐ | Poor circulation | ☐ | ☐ | Angina | ☐ | ☐ | Excessive bruising |

**D. Respiratory**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Asthma | ☐ | ☐ | Apnea | ☐ | ☐ | Emphysema | ☐ | ☐ | Hay fever | ☐ | ☐ | Shortness of breath | ☐ | ☐ | Pnumonia |

**E. Digestive**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Anorexia/Bulimia | ☐ | ☐ | Ulcer | ☐ | ☐ | Food sensitivities | ☐ | ☐ | Heartburn | ☐ | ☐ | Constipation | ☐ | ☐ | Diarrhea |

**F. Sensory**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Blurred vision | ☐ | ☐ | Ringing in the ears | ☐ | ☐ | Hearing loss | ☐ | ☐ | Chronic ear infection | ☐ | ☐ | Loss of smell | ☐ | ☐ | Loss of taste |

**G. Integumentary**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Skin cancer | ☐ | ☐ | Psoriasis | ☐ | ☐ | Eczema | ☐ | ☐ | Acne | ☐ | ☐ | Hair loss | ☐ | ☐ | Rash |

**H. Endocrine**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Thyroid issues ☐ | ☐ | | Immune disorders | ☐ | ☐ | Hypoglycemia | ☐ | ☐ | frequent infection | ☐ | ☐ | Swollen glands | ☐ | ☐ | Low energy |

**I. Genitourinary**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Kidney stones | ☐ | ☐ | Infertility | ☐ | ☐ | Bedwetting | ☐ | ☐ | Prostate issues | ☐ | ☐ | Erectile dysfunction | ☐ | ☐ | PMS symptoms |

**J. Constitutional**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Fainting | ☐ | ☐ | Low libido | ☐ | ☐ | Poor appetite | ☐ | ☐ | Fatigue | ☐ | ☐ | Sudden weight gain/loss | ☐ | ☐ | Weakness |

## Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

### 13. Illnesses

Check the illnesses you have had in the past or have now.

| Had | Have | | Had | Have | |
|---|---|---|---|---|---|
| ☐ | ☐ | AIDS | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Alcoholism | ☐ | ☐ | Typhoid fever |
| ☐ | ☐ | Allergies | ☐ | ☐ | Ulcer |
| ☐ | ☐ | Arteriosclerosis | ☐ | ☐ | Other: _____ |
| ☐ | ☐ | Cancer | _____ | | |
| ☐ | ☐ | Chicken pox | _____ | | |
| ☐ | ☐ | Diabetes | _____ | | |
| ☐ | ☐ | Epilepsy | _____ | | |
| ☐ | ☐ | Glaucoma | _____ | | |
| ☐ | ☐ | Goiter | _____ | | |
| ☐ | ☐ | Gout | | | |
| ☐ | ☐ | Heart disease | | | |
| ☐ | ☐ | Hepatitis | | | |
| ☐ | ☐ | HIV Positive | | | |
| ☐ | ☐ | Malaria | | | |
| ☐ | ☐ | Measles | | | |
| ☐ | ☐ | Multiple Sclerosis | | | |
| ☐ | ☐ | Mumps | | | |
| ☐ | ☐ | Polio | | | |
| ☐ | ☐ | Rheumatic fever | | | |
| ☐ | ☐ | Scarlet fire | | | |
| ☐ | ☐ | STD | | | |
| ☐ | ☐ | Stroke | | | |

### 14. Operations

Surgical interventions which mat or may not have included hospitalization.

☐ Appendix removal
☐ Bypass surgery
☐ Cancer
☐ Cosmetic surgery
☐ Elective surgery : _____
_____
☐ Eye surgery
☐ Hysterectomy
☐ Pacemaker
☐ Spine: _____
_____
_____
☐ Tonsillectomy
☐ Vasectomy
☐ Other: _____
_____
_____
_____

### 15. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**

| Past | Currently | |
|---|---|---|
| ☐ | ☐ | Acupuncture |
| ☐ | ☐ | Antibiotics |
| ☐ | ☐ | Birth control pills |
| ☐ | ☐ | Blood transfusions |
| ☐ | ☐ | Chemotherapy |
| ☐ | ☐ | Chiropractic care |
| ☐ | ☐ | Dialysis |
| ☐ | ☐ | Herbs |
| ☐ | ☐ | Homeopathy |
| ☐ | ☐ | Hormone replacement |
| ☐ | ☐ | Inhaler |
| ☐ | ☐ | Massage therapy |
| ☐ | ☐ | Physical therapy |
| ☐ | ☐ | Nutritional supplements : |
| | | _____ |
| | | _____ |
| | | _____ |
| | | _____ |
| ☐ | ☐ | Medications: |
| | | _____ |
| | | _____ |
| | | _____ |
| | | _____ |
| | | _____ |
| | | _____ |

### 16. Injuries

Have you ever…

☐ Had a fracture or broken bone
☐ Had a spine or nerve disorder
☐ Been knocked unconscious
☐ Been injured in an accident
☐ Used a crutch or other support
☐ Used neck or back bracing
☐ Received a tattoo
☐ Had a body piercing

### 17. Family history

Some health issues are hereditary. Tell your doctor of your immediate family members.

| Relative | Age | State of health | | Illnesses | Age of death | Cause of death | |
|---|---|---|---|---|---|---|---|
| | | Good | Poor | | | Natural | Illness |
| Mother | _____ | ☐ | ☐ | _____ | _____ | ☐ | ☐ |
| Father | _____ | ☐ | ☐ | _____ | _____ | ☐ | ☐ |
| Sister 1 | _____ | ☐ | ☐ | _____ | _____ | ☐ | ☐ |
| Sister 2 | _____ | ☐ | ☐ | _____ | _____ | ☐ | ☐ |
| Brother 1 | _____ | ☐ | ☐ | _____ | _____ | ☐ | ☐ |
| Brother 2 | _____ | ☐ | ☐ | _____ | _____ | ☐ | ☐ |
| _____ | _____ | ☐ | ☐ | _____ | _____ | ☐ | ☐ |

**18. Social history**

Inform your doctor about your health habits and stress levels.

| | | | | | | |
|---|---|---|---|---|---|---|
| Alcohol use | ☐ Daily | ☐ Weekly | How much ?_____ | Prayer or meditation? | ☐ Yes | ☐ No |
| Coffee use | ☐ Daily | ☐ Weekly | How much ?_____ | Job pressure/stress? | ☐ Yes | ☐ No |
| Tobacco use | ☐ Daily | ☐ Weekly | How much ?_____ | Financial peace? | ☐ Yes | ☐ No |
| Exercising | ☐ Daily | ☐ Weekly | How much ?_____ | Vaccinated? | ☐ Yes | ☐ No |
| Painkillers | ☐ Daily | ☐ Weekly | How much ?_____ | Mercury fillings? | ☐ Yes | ☐ No |
| Soda | ☐ Daily | ☐ Weekly | How much ? _____ | Recreational drugs? | ☐ Yes | ☐ No |
| Water intake | ☐ Daily | ☐ Weekly | How much ? _____ | | | |

Hobbies: _____

**19. Activities and daily living.**

How does this condition currently interfere with your life and ability to function?

| | None | Mild | Moderate | Severe | | None | Mild | Moderate | Severe |
|---|---|---|---|---|---|---|---|---|---|
| Sitting | ☐ | ☐ | ☐ | ☐ | Grocery shopping | ☐ | ☐ | ☐ | ☐ |
| Rising out of chair | ☐ | ☐ | ☐ | ☐ | Household chores | ☐ | ☐ | ☐ | ☐ |
| Standing | ☐ | ☐ | ☐ | ☐ | Lifting objects | ☐ | ☐ | ☐ | ☐ |
| Walking | ☐ | ☐ | ☐ | ☐ | Reaching overhead ☐ | ☐ | ☐ | ☐ | |
| Lying down | ☐ | ☐ | ☐ | ☐ | Showering or bathing | ☐ | ☐ | ☐ | ☐ |
| Climbing stairs | ☐ | ☐ | ☐ | ☐ | Dressing myself | ☐ | ☐ | ☐ | ☐ |
| Using a computer | ☐ | ☐ | ☐ | ☐ | Love life | ☐ | ☐ | ☐ | ☐ |
| Getting in/out of car | ☐ | ☐ | ☐ | ☐ | Getting to sleep | ☐ | ☐ | ☐ | ☐ |
| Driving a car | ☐ | ☐ | ☐ | ☐ | Staying asleep | ☐ | ☐ | ☐ | ☐ |
| Looking over shoulder | ☐ | ☐ | ☐ | ☐ | Concentrating | ☐ | ☐ | ☐ | ☐ |
| Caring for family | ☐ | ☐ | ☐ | ☐ | Exercising | ☐ | ☐ | ☐ | ☐ |

**20. What is the major stressor in your life?** _____

**21. How many hours do you sleep on average per night?** _____

**22. What is the type and approximate age of your mattress and pillow?**_____

_____

**23. What is your preferred sleeping position?** _____

**24. Describe your typical eating habits:** ☐ Skip breakfast ☐ 2 meals a day ☐ 3 meals a day ☐ Snacking between meals

**25. What would be the most significant thing that you could do to improve your health?** _____

_____

**26.In addition to the main reason for your visit today, what additional health goals do you have?**

_____

_____

Signature _____ Initials Doctor

Date _____