

Confidential Health History

02.09

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Childhood
Yes No Judging from stories about my birth, I would say it was difficult.
Was it... Natural Medicated Long Forceps Vacuum Cesarean
Yes No I have had at least one significant injury from sports or a fall. Year(s) and Injury(s) _____

Accidents & Falls
Yes No I have broken at least one bone. Area fractured and year _____
Yes No I've been in at least one motor vehicle accident. Year(s) & Injury(s) _____
Yes No I have had serious injuries **not** related to sports, falls or motor vehicles. Year(s) & Injury(s) _____

Surgeries & Illnesses
Yes No I have had major surgery in the past. Type & Year _____
Yes No I am or have suffered from a serious illness or disease _____

Family History
Yes No I have a family history of back pain/joint problems. If yes, please list the most relevant below:

Past Chiro Care
Yes No In the past, chiropractic has been important to my health.
My last adjustment was _____ My last chiropractor was _____
(location) _____ Were x-rays taken? Yes No
What do you want from your chiropractic care? _____

Daily Activities
Type of Work... Sitting Standing Up and Down Active
What activities and hobbies do you enjoy? _____
Who do you do these activities with 1. _____ 2. _____ 3. _____
When do you plan on giving up these activities? Now In ___ years At retirement Never
Draw an "X" on the place which best represents your commitment to Health & Wellness.
Oblivious ← _____ → Deeply Concerned

(1=Consistently, 2=most of the time, 3=some of the time, 4=not at all)

I maintain...	1	2	3	4
...a healthy/balanced diet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...regular exercise.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...a well adjusted social life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...healthy resting habits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...a positive outlook on life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...proper posture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...a constant striving for health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

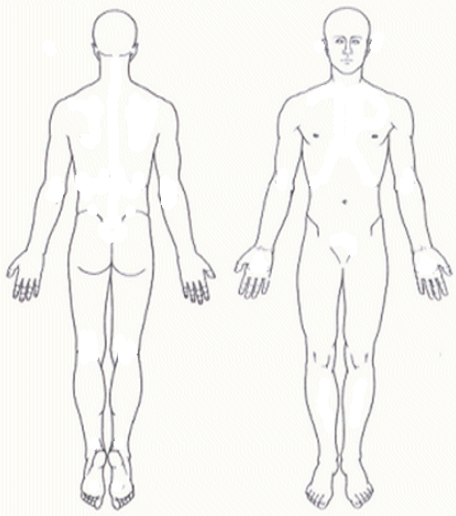
Women Only
Yes No Are you pregnant? If yes, due date ___/___/___
Do you experience:
Yes No Menstrual cramps
Yes No Irregular cycle
Yes No Premenstrual tension

Doctor's Notes

Describe your Symptoms	When Began	Intensity of Symptoms No pain → Worst pain	Best described as . . . 1. Sharp 2. Dull Ache 3. Weak 4. Throbbing 5. Numb 6. Burning 7. Stiff	Symptom is . . . 1. Constant (76% - 100%) 2. Frequent (50% - 75%) 3. Occasional (26% - 50%) 4. Intermittent (≤25%)	Symptom is . . . 1. Worsening 2. Staying the Same 3. Improving
Neck		0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7	1 2 3 4	1 2 3
Mid-back		0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7	1 2 3 4	1 2 3
Low-back		0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7	1 2 3 4	1 2 3
Pelvis/Hips		0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7	1 2 3 4	1 2 3
Other:		0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7	1 2 3 4	1 2 3

Symptoms

• Using the diagram below, shade areas to indicate location of pain or discomfort



• Check the appropriate box for your symptoms
0 = Non-existent, 1 = Mild, 2 = Moderate, 3 = Severe

0 1 2 3

Additional Complaints

- Arms/Shoulder pain
- Chest pain
- Difficult breathing
- Dizziness
- Fatigue
- Headache (s)
- Irritability
- Leg pain
- Nausea
- Nervousness
- Numbness Hands/Fingers
- Numbness Legs/Feet/Toes
- Stress Level since symptom began
- Vision disturbances

Other

• Rate the intensity in the following situation:
0 = Nonexistent, 1 = Mild, 2 = Moderate, 3 = Severe

0 1 2 3

- Daily activities
- Work
- Recreation
- Sleep
- Morning
- Afternoon
- Evening
- Nighttime

List all current medications and modalities (eg. ice, heat, traction, etc.) that you use: _____

List names and specialties of the doctors / providers you have seen for this condition: _____

This condition has caused me...

- No lost work
- Continued to work with modification
- Lost ___ days of work

Additional Info

Duration of Episode > 1 wk, 1-6 wks, >6 wks
Prior Episodes: None, 1-3, 4 or more

Stresses

- Martital/finacial stress Yes No
- Leagal/medical stress Yes No
- Skeletal anomaly or pathology related to injury Yes No

Doctor's Notes
