Personal Health Information

Date:

Last Name:		❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms.	Marital status (circle one)
First Name:	Middle:			Single / Mar / Div / Sep / Widow
Email:		Birth date:	Age:	Sex:
Address:	City:		State:	
ZIP Code:	Social Security No.:	Phone #'s: Cell: Home:		Work:
Occupation:	Employer:		#Hours/week:	

Medical Care Information

Do You Have a Family M.D.?: ☐ No ☐ Yes, Name of M.D.:

Address:	City:	State:	PH#:
Date of last Visit: / /	Date of last exam: / /		

Have you seen a Chiropractor before?: ☐ No ☐ Yes, Name of Chiropractor:

Address:	City:	State:	PH#:
Date of last Visit: / /	Date of last exam: / /		

Have you had surgeries in the last 5 Years: ☐ Yes ☐ No If yes, Last Surgery Date:

Please list all Surgeries:

Present illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐ Fibromyalgia
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐ Chronic Fatigue
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐

Comments/other:

Family History of Illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus

Other:

If yes to Cancer, What type? ☐ Breast ☐ Lung ☐ Prostate ☐ Other:

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

Hobbies:

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Do you take medications (including OTC)? ☐ Yes ☐ No If yes, please list for what and how long you've taken.

Do you take vitamin supplements? ☐ Yes ☐ No If yes, please list with dosage:

Sleep:

Are you able to fall asleep easily? ☐ Yes ☐ No

Do you wake up at night? ☐ Yes ☐ No If yes, why?_____ Any specific time of night? _____

Do you feel rested in the morning? ☐ Yes ☐ No How many hours on average do you sleep? _____

Do you: ☐ Have Nightmares ☐ Sleep Walk ☐ Snore ☐ Grind Teeth ☐ Have to Nap during the day

Typical Daily Diet:

Approximately how many ounces of Water do you drink per day? _____ Sodas? How much? _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks(and when): _____

Quality of Life:

What is your greatest health concern? _____

How does it limit you the most? _____

How could it affect your relationships? _____

What is your Primary Goal regarding your health?

☐ To Optimize My Health ☐ To Maintain my Current Level of Health ☐ Pain/Symptom Relief

☐ Other:

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Stresses of Life:

Research proves that physical, mental/emotional, and/or chemical stress is involved in most health conditions.
Please help us to determine the cause of your condition by answering the following questions thoroughly.

What is your most stressful situation currently?

_____

_____

_____

What do you believed caused your current condition?

_____

_____

_____

Regarding Physical Stress to the body, please indicate if you've ever experienced any of the following:

☐ Car Accidents or "Fender-Benders" ☐ Repetitive Work/tasks ☐ Poor posture habits (i.e. Slouching)

☐ Slip and/or Falls ☐ Fights/Wrestling ☐ Sports ☐ Bike Accidents ☐ Motorcycle Accidents

☐ Other: _____

Space Reserved for Office Use:

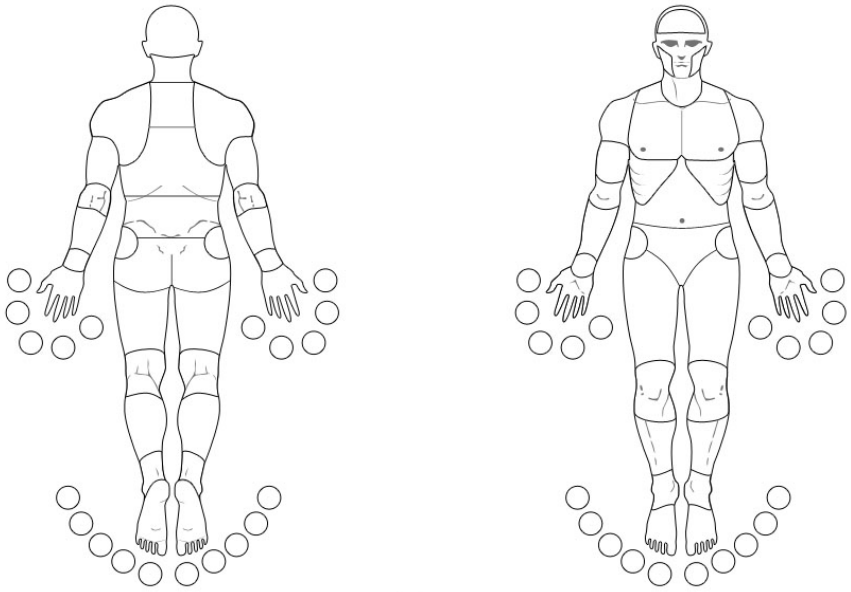
Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Personal Health Information

Name: _____ **Date:** _____

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow.



Describe Primary Problem:		
Location		☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency		☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain Type		☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning
Severity		☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it better?		☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?		☐ Movements ☐ Bending ☐ Twisting ☐ Weight Bearing ☐ Movements ☐ Neck Flexion ☐ Sneezing ☐ Sitting ☐ Standing ☐ Walking ☐ Chewing ☐ Yawning ☐ Opening mouth ☐ Closing mouth ☐ Range of motion ☐ pushing/pulling ☐ Lifting ☐ Watching T.V. ☐ Reading ☐ Working ☐ Driving ☐ Housework ☐ Bright lights ☐ Loud Noises
Does the pain radiate to any other locations?	Upper Body	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Neck ☐ Right Ear ☐ Left Ear ☐ Right Eye ☐ Left Eye ☐ Face ☐ Right Jaw ☐ Left Jaw ☐ Right Upper back ☐ Left Upper back ☐ Right Shoulder ☐ Left Shoulder ☐ Right Chest ☐ Left Chest ☐ Right Ribs ☐ Left Ribs
	Mid Body	☐ Right Mid back ☐ Left Mid back ☐ Right Lower back ☐ Left Lower back ☐ Right Hip ☐ Left Hip ☐ Right Buttock ☐ Left Buttock ☐ Groin ☐ Right Arm ☐ Left Arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
	Lower Body	☐ Right Thigh ☐ Left Thigh ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf ☐ Right Toes ☐ Left Toes ☐ Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
Described as		☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst		☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
Associated with		☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance
Comments		

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Describe Secondary Problem:		
Location		☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency		☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain Type		☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning
Severity		☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it better?		☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?		☐ Movements ☐ Bending ☐ Twisting ☐ Weight Bearing ☐ Movements ☐ Neck flexion ☐ Sneezing ☐ Sitting ☐ Standing ☐ Walking ☐ Chewing ☐ Yawning ☐ Opening mouth ☐ Closing mouth ☐ Range of motion ☐ pushing/pulling ☐ Lifting ☐ Bright lights ☐ Loud Noises ☐ Watching T.V. ☐ Reading ☐ Working ☐ Driving ☐ Housework
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Described as		☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst		☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
Associated with		☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance
Comments		

Describe Additional Problem:		
Location		☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency		☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain Type		☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning
Severity		☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it better?		☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?		☐ Movements ☐ Bending ☐ Twisting ☐ Weight Bearing ☐ Movements ☐ Neck flexion ☐ Sneezing ☐ Sitting ☐ Standing ☐ Walking ☐ Chewing ☐ Yawning ☐ Opening mouth ☐ Closing mouth ☐ Range of motion ☐ pushing/pulling ☐ Lifting ☐ Bright lights ☐ Loud Noises ☐ Watching T.V. ☐ Reading ☐ Working ☐ Driving ☐ Housework
Does the pain radiate to any other locations?	Upper Body	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Neck ☐ Right Ear ☐ Left Ear ☐ Right Eye ☐ Left Eye ☐ Face ☐ Right Jaw ☐ Left Jaw ☐ Right Upper back ☐ Left Upper back ☐ Right Shoulder ☐ Left Shoulder ☐ Right Chest ☐ Left Chest ☐ Right Ribs ☐ Left Ribs
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