PATIENT HISTORY FORM

Todays Date:	Full Name:	Age:	Date of Birth:
Preferred Name:	Res. Phone:	Bus. Phone:	
Address:	City:		State:
FEMALES: IS THERE ANY POSSIBILITY THAT YOU MIGHT BE PREGNANT? YES NO	Email:		

1. Chief Complaint and Location PLEASE LIST YOUR COMPLAINTS BELOW, STARTING WITH THE HIGHEST PRIORITY AS NUMBER 1 CHIEF COMPLAINT, 2 SECONDARY ETC.

Complaint 1:	How did this occur?

O (Onset): Date of injury or onset of symptoms

P (Palliative): What helps relieve the pain or symptoms (rest, hot bath, exercise, other)?

P (provocative): What action worsens the pain or symptoms (sitting, standing, work, coughing, etc.)?

Q (Quality): Sharp, dull, throbbing, boring, numb, tingling, shooting, ache, other?

R (Radiation): Where does the pain travel or is it localized?

S (Setting): Does it occur at work, home, exercise, A.M., P.M., etc.?

S (Severity): Mild, moderate, severe, very severe?

T (Timing): Constant or intermittent or constant with varying degrees of intensity?

P (Progression): Getting, better, worse, staying the same?

2. Secondary Complaint and Location

Complaint 2:	How did this occur?

O (Onset): Date of injury or onset of symptoms

P (Palliative): What helps relieve the pain or symptoms (rest, hot bath, exercise, other)?

P (provocative): What action worsens the pain or symptoms (sitting, standing, work, coughing, etc.)?

Q (Quality): Sharp, dull, throbbing, boring, numb, tingling, shooting, ache, other?

R (Radiation): Where does the pain travel or is it localized?

S (Setting): Does it occur at work, home, exercise, A.M., P.M., etc.?

S (Severity): Mild, moderate, severe, very severe?

T (Timing): Constant or intermittent or constant with varying degrees of intensity?

P (Progression): Getting, better, worse, staying the same?

3. Third Complaint and Location

Complaint 3:	How did this occur?

O (Onset): Date of injury or onset of symptoms

P (Palliative): What helps relieve the pain or symptoms (rest, hot bath, exercise, other)?

P (provocative): What action worsens the pain or symptoms (sitting, standing, work, coughing, etc.)?

Q (Quality): Sharp, dull, throbbing, boring, numb, tingling, shooting, ache, other?

R (Radiation): Where does the pain travel or is it localized?

S (Setting): Does it occur at work, home, exercise, A.M., P.M., etc.?

S (Severity): Mild, moderate, severe, very severe?

T (Timing): Constant or intermittent or constant with varying degrees of intensity?

P (Progression): Getting, better, worse, staying the same?

Name:	
PREVIOUS MEDICAL CARE FOR CHIEF COMPLAINT	**PREVIOUS CHIROPRACTIC CARE**
Name and location of doctor:	Date of last chiropractic exam of spine
Examinations and Xrays made	Name and location of Doctor
Condition or Diagnosis	Under treatment for what condition
Type of Treatment	Type of treatment (adjustment, therapy)
Duration of Treatment	How much time was needed on each treatment
Results of Treatment (good, fair, poor)	Frequency of treatment i.e.: # of visits per week or month
Have you ever been diagnosed as having cancer? Yes or No If Yes, Explain:	What was total time you were under care from start to finish?
	Results of treatment (good, fair, poor)
Surgeries:	FAMILY HISTORY
HABITS, DRUGS, AND VITAMINS	Has anyone ever said you had abnormal spinal development Yes/No
Average number of hours: Sleep Exercise	Is there a family history of, arthritis (A), cancer (C), diabetes (D), heart disease (H)? Please indicate below:
Tea, Coffee, Soda (how much)	
Alcohol Tobacco (packs per day)	
Are you taking any medication/drugs	
Vitamins presently being taken	
Diet	

Father side	A	C	D	H
Mother side	A	C	D	H
Father	A	C	D	H
Mother	A	C	D	H
Brother	A	C	D	H
Sister	A	C	D	H
Father side	A	C	D	H

Do you Presently (P) have or Used (U) to suffer the following Conditions?

Allergy	Swollen joints	Bruise easily	Prostate trouble
Dizziness	Colon trouble	Hay Fever	Backache
Fatigue	Diarrhea	Nose bleeds	Alcoholism
Headache	Difficult digestion	Sinus infection	Diabetes
Loss of Sleep	Hemorrhoids	High blood pressure	Polio
Ulcers	Nausea	Pain over heart	Swelling ankles
Nervousness	Asthma	Poor circulation	Cancer of:
Depression	Colds	Rapid heart beat	Spinal Curvature
Arthritis	Deafness	Slow heart beat	**Gynecological Issues**
Bursitis	Ear Noises	Anemia	Cramps
Foot Trouble	Enlarged Thyroid	Stroke	Heavy Flow
Low Back Pain	Eye pain	Chest pain	Irregular cycle
Neck pain/Stiffness	Failing vision	Difficult breathing	Hot flashes
Poor Posture	Venereal Disease	Pleurisy	Lumps in breast
Sciatica	A.I.D.S.	Spitting	**Other Conditions**
		Itching	

Tingling or Numbness		**Are using:**	Varicose veins	
Shoulder	Hips	Heel lifts	Bed wetting	
Arms	Legs	Sole lifts	Frequent urination	
Elbows	Knees	Insoles	Kidney infection	
Hands	Feet	Arch supports	Kidney stones	

Name of person responsible for payment: _____

Are you insured? YES / NO, Ins. Company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. Any time a credit balance exist on my account I understand that I request that balance be paid directly to me with in seven work days. I also give this office **power of attorney** to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date_____

Guardian / Parent Authorizing Care of Minor Child or Dependant_____