

Personal and Family Health History

Name _____ Date: _____ Who should we thank for referring you? _____

Address _____ Social Security # _____

City _____ State _____ Zip _____ Occupation _____

Phone: Home _____ Cell _____ Work _____

Date of Birth _____ Age _____

Spouse's Name _____ Marital Status S M D W

Email: _____

Drivers License # _____ Spouse's Occupation _____

Personal Health Insurance _____ ID# _____

Insured Persons Name _____ Insured's Date of Birth _____

What brings you to our office today?

Pain or problem started on? _____ How did it begin? _____

Is this condition: ___ Job Related ___ Auto Accident ___ Home Injury ___ Fall ___ Other _____

Pains are: Sharp Dull Constant Intermittent.

Is this condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Hobbies? _____ Other? _____

What other activities that you enjoy does this interfere with? _____

Is this condition getting progressively worse? _____

Has this occurred before? _____ If so how often? _____

Previous Chiropractic Care? ___ None ___ Yes. If so approximate last visit? _____

Any home remedies? ___ Ice Heat ___ Over the counter drugs ___ Other _____

Have you ever been involved in any accidents? When? Please Explain:

Have you been under drug or medical care for this condition? By whom? What were the results?

Have you had any surgery or organs removed? If so what and when? _____

Other Symptoms:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Pins & Needles in Legs	<input type="checkbox"/> Fainting	<input type="checkbox"/> Heart Burn
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Pins & Needles in Arms	<input type="checkbox"/> Cold Sweats	<input type="checkbox"/> Frequent Nausea
<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Numbness in Fingers	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Allergies
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Numbness in Toes	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Stress
<input type="checkbox"/> Tension	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Feet Cold	<input type="checkbox"/> Buzzing in Ear
<input type="checkbox"/> Irritability	<input type="checkbox"/> Depression	<input type="checkbox"/> Hands Cold	<input type="checkbox"/> Fever
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Stomach Upset	<input type="checkbox"/> Neck Stiff
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Leg pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Loss of Memory
<input type="checkbox"/> Face Flushed		<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Ears Ring
<input type="checkbox"/> Sinus Problems		<input type="checkbox"/> Ear Infections	<input type="checkbox"/>

Dr. Richardson is a Certified Chiropractic Extremity Practitioner. (C.C.E.P.) That is to say, he has completed additional course work in areas other than the spine. **Please mark down if you are having any problems in the following areas.**

- Jaw pain or clicking (TMJ) R or L
 - Shoulder pain R or L
 - Elbow pain R or L
 - Toe Pain R or L
 - Ankle Pain R or L
 - Foot Pain R or L
 - Knee Pain R or L
 - Wrist pain R or L
 - Carpal Tunnel R or L
- ___ Thumb pain R or L
 - ___ Rib pain (Front, back or side) R or L
 - ___ Hip pain R or L

Circle all that apply

Do you drink?	Y	Exercise regularly?	Y
Diet (do you eat healthy foods?)	Y	Have sleeping problems?	Y
Have Teeth Problems?	Y	Have occupational stress?	Y
Have Eye Problems?	Y	Have physical stress?	Y
Have Hearing Problems?	Y	Have mental stress?	Y
		Have hobbies/sports injuries?	Y

Sleeping posture, please circle one or more: side stomach back

How many pillows do you sleep with under your head? Do you use none, 1, 2 or more? _____

Do you scrunch your pillow? Y N

Do you put an arm or hand under your pillow? Y N

Do you use a body pillow? Y N

As a result of my chiropractic care, I would like to (Please check all that apply)

- Have a healthier spine and nervous system.
- Live a healthier lifestyle.
- Feel better quickly.

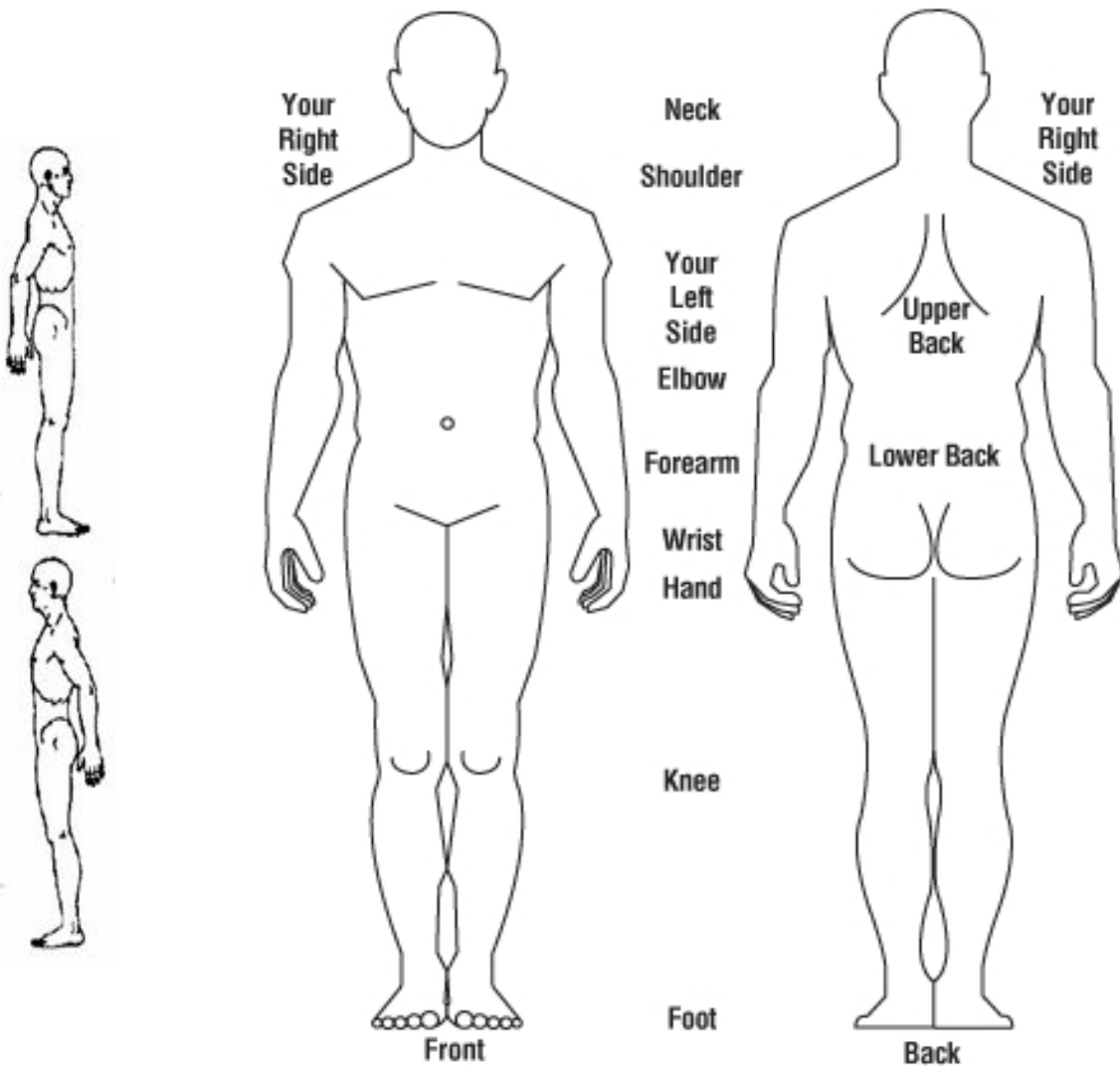
Signature

Date

Patient Name (Print) _____ Date _____

Please draw the location of your pain or discomfort on the images below. Use symbols shown to represent the type(s) of pain :

A= Ache D= Dull S=Stabbing/cutting SH= Sharp B= Burning N= Numb
T= Tingling/Pins and Needles C=Cramping TH=Throbbing O= Other



Do you have the pain 25% 50% 75% 100 % of the day? (Circle one)

How many days a week do you have the pain? 1 2 3 4 5 6 7

Patient Name: _____

Date: _____

Complaint #1: _____

What is your pain for complaint #1 RIGHT NOW?

No pain _____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What is your **TYPICAL** or **AVERAGE** pain (over the last month)?

No pain _____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What is your pain at its **BEST** (How close to "no pain" does your pain get at its best)?

No pain _____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What relieves your pain? _____

What is your pain at its **WORST** (How close to "excruciating" does your pain get at its worst)?

No pain _____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse? _____

Complaint #2: _____

What is your pain for complaint #2 RIGHT NOW?

No pain _____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What is your **TYPICAL** or **AVERAGE** pain (over the last month)?

No pain _____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What is your pain at its **BEST** (How close to "no pain" does your pain get at its best)?

No pain _____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What relieves your pain? _____

What is your pain at its **WORST** (How close to "excruciating" does your pain get at its worst)?

No pain _____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse? _____