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:

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

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.

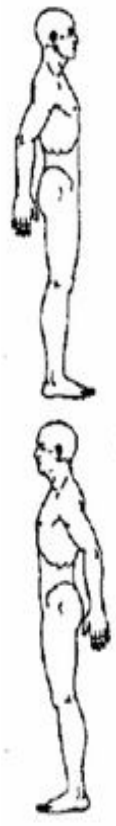
Signature Date

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? _____