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?

_____

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	❒

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

_____

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

Your oldest grandparent on record lived to the age of _____. If still alive put their age.

❒ Still living ❒ Deceased

You deserve to be healthy. When you were conceived, you were given the blueprints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal quickly and live the quality lifestyle you deserve.

Circle all that Apply

Chiropractors *Comments*

Growth and Development

As a child and growing up Did you ever once...	*Patient*	*Spouse*	*Child #1*	*Child #2*	*Child #3*	
Learn to care for your spine?						
Fall out of bed?	Y	Y	Y	Y	Y	_____
Bang your head?	Y	Y	Y	Y	Y	_____
Childhood sickness?	Y	Y	Y	Y	Y	_____
Have any Accidents?	Y	Y	Y	Y	Y	_____

Have Surgery?	Y	Y	Y	Y	Y	_____
Take Drugs?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	Y	Y	Y	Y	Y	_____
Bullied by your siblings?	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down the stairs?	Y	Y	Y	Y	Y	_____
Pulled by your arm?	Y	Y	Y	Y	Y	_____
Experience other traumas?	Y	Y	Y	Y	Y	_____
Fall of a bike?	Y	Y	Y	Y	Y	_____

Current Health Habits

	Patient	*Spouse*	*Child #1*	*Child #2*	*Child #3*	***Chiropractors Comments***
Do you drink?	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_____
Have Teeth Problems?	Y	Y	Y	Y	Y	_____
Have Eye Problems?	Y	Y	Y	Y	Y	_____
Have Hearing Problems?	Y	Y	Y	Y	Y	_____
Exercise regularly?	Y	Y	Y	Y	Y	_____
Have sleeping problems?	Y	Y	Y	Y	Y	_____
Have occupational stress?	Y	Y	Y	Y	Y	_____
Have physical stress?	Y	Y	Y	Y	Y	_____
Have mental stress?	Y	Y	Y	Y	Y	_____
Have hobbies/sports injuries?	Y	Y	Y	Y	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

Chiropractic Care is for the whole family, from Newborns to 100. Please consider a complimentary evaluation for your children and/or your parents. Please ask us.

Number of Children and Ages	***Previous Chiropractic Care?***
Name _____	Age _____ Yes___ No___ Reason _____
Name _____	Age _____ Yes___ No___ Reason_____
Name _____	Age _____ Yes___ No___ Reason_____

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss your treatment recommendations . These recommendations are designed to get you feeling better quickly and to help you be as healthy as possible. Our goals are to help you not only recover from your current problem but provide you with a way to lead a healthier and pain free life.

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

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

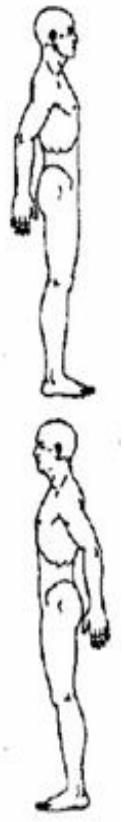
Signature Date

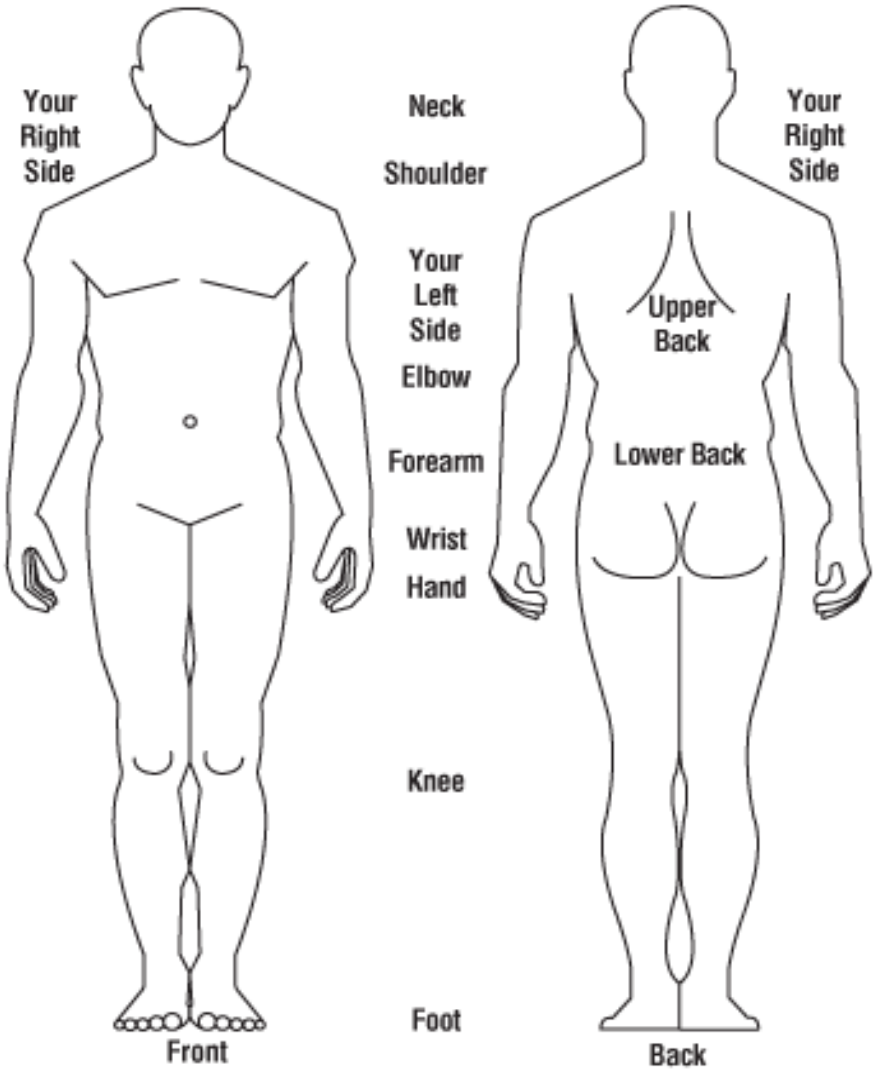
Patient Name(Print)_____Date_____

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? _____