Welcome To Chiropractic FIRST

Please Print Clearly and Fill in Completely

CONFIDENTIAL PATIENT HEALTH RECORD Date: _____

PERSONAL HISTORY

Name: _____ Birth Date: _____ Age: _____

Address: _____ Sex: Male / Female

City: _____ State: _____ Zip: _____ Home Phone: _____

Social Security #: _____ Cell Phone: _____

Driver's License #: _____ E-mail Address: _____

Business Employer: _____ Fax #: _____

Occupation: _____ Business Phone: _____

Name of Spouse: _____ Spouse's Employer: _____

Type of Work: _____ Names & Ages of Children: _____

Referred To This Office By: _____ _____

Name & Number of Emergency Contact & Relationship: _____

Current Primary Physician Contact Information _____

Who is responsible for your bill? You and ☐Spouse ☐Worker's Comp ☐Auto Insurance ☐Medicare ☐Medicaid

Personal Health Insurance Carrier: _____ Health Card ID #: _____

Insured Person's Name: _____ Group #: _____

Insured Person's Date of Birth: _____ Have you had previous chiropractic care? ☐ Yes ☐ No

Insured Person's Social Security #: _____ Name of Previous Chiropractor: _____

CURRENT HEALTH CONDITION

SYMPTOMS: When this problem is at its worst, please explain in your words how exactly it feels? _____

_____

When did this condition begin? _____

MECHANISM OF ONSET: Before you began to suffer with this problem, was there an earlier accident, injury, or condition that may or may have been directly related to this problem? (Example: fall, auto injury, sports trauma, repetitive motion on the job) _____

_____

_____

VERTEBRAL SUBLUXATIONS IRRITATE DIFFERENT FIBERS IN NERVES; WHICH BEST DESRCRIBES YOUR CONDITION:

☐ Burning ☐ Diffuse ☐ Dull / Aching ☐ Localized ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Tingling

☐ Radiating ☐ Other: _____

VERTEBRAL SUBLUXATIONS CAN PUT PRESSURE ON THE SPINAL CORD THAT FEELS CONSTANT OR OCCASIONAL. WHEN AND WHICH DO YOU FEEL?

☐ Worse AM ☐ Worse PM ☐ Worse with activity ☐ Intermittent ☐ Constant ☐ Worse at night

How often do you find yourself suffering from this problem? _____

How long does the problem last? (Provide all details on timing) _____

Is condition: ☐Auto related ☐Work related ☐Other ☐No injury

Explain: _____

Date/Time of Accident: _____

DAILY ACTIVITIES

Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yardwork	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

SOCIAL HISTORY QUESTIONAIRRE

OCCUPATION

Job Title: _____ **Work Hours Per Day:** _____

Max Lifting Requirement: ☐ Min (<5 lbs) ☐ Light (5-20 lbs) ☐ Med (20-50lbs) ☐ Hvy (>50 lbs)
Lifting Frequency: ☐ Constant (66-100%of day) ☐ Frequent (33-66% of day) ☐ Occasional (0-33% of day)
Lifting Postures: ☐ Knee ☐ Torso ☐ Arm ☐ Shoulder ☐ Off Posture
Alcohol: # Drinks per week_____
Tobacco # Packs per week_____

Family

History of Heart Disease? **Paternal** **Maternal**
History of Cancer? **Paternal** **Maternal**
Other? _____

MEDICATIONS: What medications are you currently taking and for what condition? _____

_____

_____

Has there been any other injury to your spine you feel the Doctor should know about? _____

_____

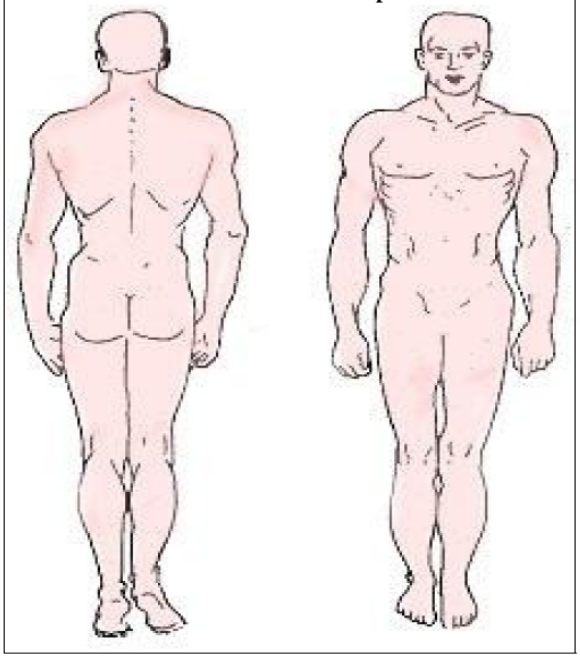
_____

_____

Please Fill in Below If you have had the following, or if you suffer from the following, ***Please Check*** ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Frequent colds	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Female problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other _____	❑	❑

Circle the areas where you have any problems.
Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

_____

Date: _____