

Patient Name _____ Date _____

History of Present Illness

Chief Complaint/Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Name and Phone Number of Physician: _____

Pain Level: (1-10, 10 being worst) 1 2 3 4 5 6 7 8 9 10

Are the symptoms: Constant (75-100%) Frequent (50-75%) Intermittent (25-50%) Occasional (0-25%)

Quality of Pain: Dull Aching Sharp Shooting Burning Numb Tingling Throbbing Pounding Other _____

Does the pain radiate down the arms or legs? No Yes - How far: _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Is this due to: Auto Work Sport Home Unknown Other _____

Have you ever had the same or similar condition? Yes No If yes, when and describe _____

Have you been treated by any other chiropractor or medical doctor in the last year? _____

Medications: _____

History of accidents: _____

History of surgeries/broken bones: _____

Allergies: _____

Other Complaints: _____

Family History

Condition	Mother	Father	Sibling	Grandparent	Deceased ?
Cancer					
Diabetes					
Heart Disease					
Heart Attack					
High Blood Pressure					
Stroke					
Headaches					
Back Problems					

REVIEW OF SYSTEMS Check only the ones you now have or have had in the past.

GENERAL	NOW	PAST
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Lumps / Masses	<input type="checkbox"/>	<input type="checkbox"/>
Location _____		

HEAD	NOW	PAST
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
seirujnI	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fo ssoL		
Consciousness	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> scatnoC/sessalG		<input type="checkbox"/>
_____/_____/____ :etaD maxE eyE tsaL		

EARS	NOW	PAST
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>

NOSE	NOW	PAST
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>

MOUTH	NOW	PAST
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>
Grind Teeth?	Yes	No
Jaw Click/Snap	Yes	No

THROAT	NOW	PAST
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Snoring	Yes	No

LUNGS	NOW	PAST
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>

HEART	NOW	PAST
Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation	<input type="checkbox"/>	<input type="checkbox"/>
Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>

BLOOD	NOW	PAST
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>
Painful Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>

INTESTINAL	NOW	PAST
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Daily Bowel Movement?		
Yes	<input type="checkbox"/>	No <input type="checkbox"/>

URINARY	NOW	PAST
Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Straining	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sehsalF toH	<input type="checkbox"/>	<input type="checkbox"/>

Last Pap/Pelvic Exam: _____/_____/_____

Last Mammogram: _____/_____/_____

Could You Be Pregnant?

YES NO

Approx. Due Date: _____/_____/_____

Enlarged Prostate

Last Prostate Exam: _____/_____/_____

NEUROLOGIC	NOW	PAST
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Hand Trembling	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Balance	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGIC	NOW	PAST
Loss of Facial Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Weak Grip	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Difficult Speech	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>

PAST MEDICAL HISTORY

Check only those you have had in the past

Angina

Heart Attack

Hypertension / High Blood Pressure

Stroke

Gallstones

Hepatitis

Epilepsy

Alcoholism

Depression

Gout

Diabetes

Kidney Stones

Cancer

Type of Cancer: _____

Tumor

Type of Tumor: _____

Arthritis

Type of Arthritis: _____

Location: _____

Do You Have A Pacemaker?

SEY ON