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	❑	❑
Fatigue	❑	❑
Chills	❑	❑
Night Sweats	❑	❑
Fainting	❑	❑
Lumps / Masses	❑	❑

Location ______________

HEAD	NOW	PAST
Headaches	❑	❑
Injuries	❑	❑
Loss of Consciousness	❑	❑
Glasses/Contacts	❑	❑

Last Eye Exam Date: ___/___/___

EARS	NOW	PAST
Hard of Hearing	❑	❑
Ringing	❑	❑
Earache	❑	❑

NOSE	NOW	PAST
Decreased Smell	❑	❑
Bleeding	❑	❑

MOUTH	NOW	PAST
Loss of Taste	❑	❑
Grind Teeth?	YES	NO
Jaw Click/Snap	YES	NO

THROAT	NOW	PAST
Sore Throat	❑	❑
Trouble Swallowing	❑	❑
Frequent Snoring	YES	NO

LUNGS	NOW	PAST
Cough	❑	❑
Wheezing	❑	❑

HEART	NOW	PAST
Murmur	❑	❑
Palpitation	❑	❑
Rapid Heartbeat	❑	❑
Swollen Extremities	❑	❑
Cold Extremities	❑	❑
Blood Clots	❑	❑

BLOOD	NOW	PAST
Anemia	❑	❑
Easy Bruising	❑	❑
Swollen Lymph Nodes	❑	❑
Painful Lymph Nodes	❑	❑

INTESTINAL	NOW	PAST
Abdominal Pain	❑	❑
Heartburn	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Hemorrhoids	❑	❑
Loss of Appetite	❑	❑

Daily Bowel Movement? YES NO

URINARY	NOW	PAST
Urgency	❑	❑
Incontinence	❑	❑
Straining	❑	❑
Frequent Voiding	❑	❑
Burning	❑	❑
Irregular Periods	❑	❑
Hot Flashes	❑	❑

Last Pap/Pelvic Exam:___/___/___

Last Mammogram: ___/___/___

Could You Be Pregnant? YES NO

Approx. Due Date? ___/___/___

Enlarged Prostate ❑ ❑

Last Prostate Exam: ___/___/___

NEUROLOGIC	NOW	PAST
Seizures	❑	❑
Vertigo	❑	❑
Dizziness	❑	❑
Hand Trembling	❑	❑
Loss of Sensation	❑	❑
Loss of Balance	❑	❑
Loss of Facial Sensation	❑	❑
Weak Grip	❑	❑
Paralysis	❑	❑
Difficult Speech	❑	❑
Loss of Memory	❑	❑

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? YES NO