

Confidential Patient History Form

Initial Intake Form

Date: _____

Personal Information

Patient Name: Last: _____ First: _____ Middle: _____

Title: Mr. Mrs. Ms Miss Dr. Atty. Rev. Prof. Other: _____

Suffix: Jr. Sr. II III MD DO DC PA Esq. RN BSN Other _____

Birth Date: ____/____/____ Age: _____ Sex: Male Female Social Security #: ____/____/____

Driver's License #: _____ State: _____

Race: African-American Asian Caucasian Hispanic Multiracial Native American Other: _____

Marital Status: Single Married Widowed Divorced Separated

Address: _____ Apt. # _____

City: _____ State: _____ Zip code: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Work Phone: (____) _____ - _____ Ext. #: _____ Fax #: (____) _____ - _____

Email Address: _____

Spouses Name: _____ Children (names & Ages): _____

Emergency Contact Person

Last Name: _____ First: _____ Middle: _____

Title: Mr. Mrs. Ms Miss Dr. Atty. Rev. Prof. Other: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip code: _____

Relationship: Spouse Relative Friend Other: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Work Phone: (____) _____ - _____ Ext. #: _____

Eyes / Vision: Check the appropriate box if you are having or had any of the symptoms or problems listed below:

- | | | | |
|---|---|-------------------------------------|--|
| <input type="checkbox"/> blindness | <input type="checkbox"/> change in vision | <input type="checkbox"/> field cuts | <input type="checkbox"/> photophobia |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> double vision | <input type="checkbox"/> glaucoma | <input type="checkbox"/> tearing |
| <input type="checkbox"/> cataracts | <input type="checkbox"/> eye pain | <input type="checkbox"/> itching | <input type="checkbox"/> wear glasses / contacts |

Ears, Nose and Throat: Check the appropriate box if you are having or had any of the symptoms or problems listed below:

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> bleeding | <input type="checkbox"/> ear drainage | <input type="checkbox"/> hearing loss | <input type="checkbox"/> nose bleed | <input type="checkbox"/> sore throat |
| <input type="checkbox"/> dentures | <input type="checkbox"/> ear pain | <input type="checkbox"/> Hx of head injury | <input type="checkbox"/> postnasal drip | <input type="checkbox"/> tinnitus (ringing in ears) |
| <input type="checkbox"/> difficult swallowing | <input type="checkbox"/> fainting spells | <input type="checkbox"/> hoarseness | <input type="checkbox"/> runny nose | <input type="checkbox"/> TMJ problems |
| <input type="checkbox"/> discharge | <input type="checkbox"/> frequent sore throat | <input type="checkbox"/> loss of smell | <input type="checkbox"/> sinus infections | |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> headaches | <input type="checkbox"/> nasal congestion | <input type="checkbox"/> snoring | |

Respiration: Check the appropriate box if you are having or had any of the symptoms or problems listed below:

- | | | |
|---------------------------------|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> coughing up blood | <input type="checkbox"/> sputum production |
| <input type="checkbox"/> cough | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> wheezing |

Cardiovascular: Check the appropriate box if you are having or had any of the symptoms or problems listed below:

- | | | |
|--|--|--|
| <input type="checkbox"/> angina (chest pain or discomfort) | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> shortness of breath with exertion or exercise |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> swelling of legs |
| <input type="checkbox"/> claudication (leg pain/ache) | <input type="checkbox"/> orthopnea (difficulty breathing lying down) | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> palpitations | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> paroxysmal nocturnal dyspnea (waking at night with shortness of breath) | |

Gastrointestinal: Check the appropriate box if you are having or had any of the symptoms or problems listed below:

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea | <input type="checkbox"/> indigestion | <input type="checkbox"/> abnormal stool | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> belching | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> jaundice | <input type="checkbox"/> abnormal stool color | |
| <input type="checkbox"/> black-tarry stools | <input type="checkbox"/> heart burn | <input type="checkbox"/> nausea | <input type="checkbox"/> abnormal stool consistency | |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting | |

Female: Check the appropriate box if you are having or had any of the symptoms or problems listed below:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> birth control | <input type="checkbox"/> cramps | <input type="checkbox"/> irregular menstruation | <input type="checkbox"/> vaginal bleeding |
| <input type="checkbox"/> breast lumps/pain | <input type="checkbox"/> frequent urination | <input type="checkbox"/> pregnancy | <input type="checkbox"/> vaginal discharge |
| <input type="checkbox"/> burning urination | <input type="checkbox"/> hormone therapy | <input type="checkbox"/> urine retention | |

Male: Check the appropriate box if you are having or had any of the symptoms or problems listed below:

- | | | |
|---|--|--|
| <input type="checkbox"/> burning urination | <input type="checkbox"/> frequent urination | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy / dribbling | <input type="checkbox"/> urine retention |

PAST MEDICAL HISTORY: Fill out carefully as these problems can affect your overall course of care.

Previous Care:

Have you been treated in the past by a physician for any of the above listed conditions? Yes No

If Yes; name of the physician: _____

Have you received Chiropractic care in the past? Yes No

Were you satisfied with your Chiropractic care? Yes No If No; why not: _____

Family Physician & other Health Care Provider(s):

Doctors Name: _____ Date of Last Visit: _____

Doctors Address: _____ Phone #: (_____) _____ - _____

Additional Doctors Name & Addresses: _____

Current Medication(s): List all medications and why you are taking them:

Current Vitamins, Herbs, etc.: List all non-prescription items you are currently taking and reason for taking them:

Childhood Illness (es): List all health conditions. Circle all Current conditions:

- | | | | |
|---|--|------------------------------------|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> chicken pox | <input type="checkbox"/> headaches | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> eczema (atopic dermatitis) | <input type="checkbox"/> crohn's / colitis | <input type="checkbox"/> hepatitis | <input type="checkbox"/> seizure disorder |
| <input type="checkbox"/> allergies / hay fever | <input type="checkbox"/> depression | <input type="checkbox"/> HIV | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes | <input type="checkbox"/> measles | <input type="checkbox"/> spina bifida |
| <input type="checkbox"/> asthma | <input type="checkbox"/> ear infection(s) | <input type="checkbox"/> mumps | <input type="checkbox"/> other: |
| <input type="checkbox"/> bedwetting | <input type="checkbox"/> fetal drug exposure | <input type="checkbox"/> psoriasis | |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> food allergies | <input type="checkbox"/> rash | |

Adult Illness: List all health conditions. CIRCLE all CURRENT conditions:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> colitis | <input type="checkbox"/> hypertension (high blood pressure) | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> anemia | <input type="checkbox"/> depression | <input type="checkbox"/> influenzal pneumonia | <input type="checkbox"/> spinal scoliosis |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes(insulin dep) | <input type="checkbox"/> liver disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> asthma | <input type="checkbox"/> diabetes(no insulin) | <input type="checkbox"/> lung disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> cancer | <input type="checkbox"/> eczema | <input type="checkbox"/> lupus erythema (discoïd) | <input type="checkbox"/> stomach problems |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> emphysema | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> STD's (unspecified) |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> crohn's / colitis | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> heart disease | <input type="checkbox"/> pleural effusion (lung problems) | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> vision problems |
| <input type="checkbox"/> cystic kidney | <input type="checkbox"/> HIV/HIV positive | <input type="checkbox"/> psoriasis | |
| <input type="checkbox"/> Other conditions not listed: _____ | | | |

Surgical History: LIST ALL Surgical Procedures. Write the DATE of the Procedure beside the procedure:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental surgery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsillectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | |
| <input type="checkbox"/> coronary artery by-pass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | |
| Other surgery not listed: _____ | | | |

Injury (ies): Mark or List all Injuries. Write the DATE of the injury immediately afterward:

- | | | |
|---|---|--|
| <input type="checkbox"/> back injury | <input type="checkbox"/> head injury (loss of consciousness) | <input type="checkbox"/> motor vehicle accident |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild) |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe) | <input type="checkbox"/> joint injury | <input type="checkbox"/> soft tissue injury (severe) |
| <input type="checkbox"/> fracture | <input type="checkbox"/> laceration (severe) | <input type="checkbox"/> scars |
| <input type="checkbox"/> Other injury not listed: _____ | | |

