CHIROPRACTIC NEW PATIENT HEALTH HISTORY INTAKE

Full Name: ____ **Date of Birth:** ______________

Current condition:

Main concern that brings you into the office: ____

When did this concern begin? ____

When are your symptoms better? MORNING / AFTERNOON / NIGHT / NO CHANGE

When are your symptoms worse? MORNING / AFTERNOON / NIGHT / NO CHANGE

How would you describe the pain? DULL / ACHY / SHARP / SHOOTING / TINGLING / NUMB /
OTHER ____

Does your pain radiate anywhere? Describe: ____

What is the severity of your pain? *(Circle)* NONE 1 2 3 4 5 6 7 8 9 10 SEVERE

How often do you experience this pain? SPORADIC / OCCASIONAL / INTERMITTENT /

CONSTANT / OTHER____

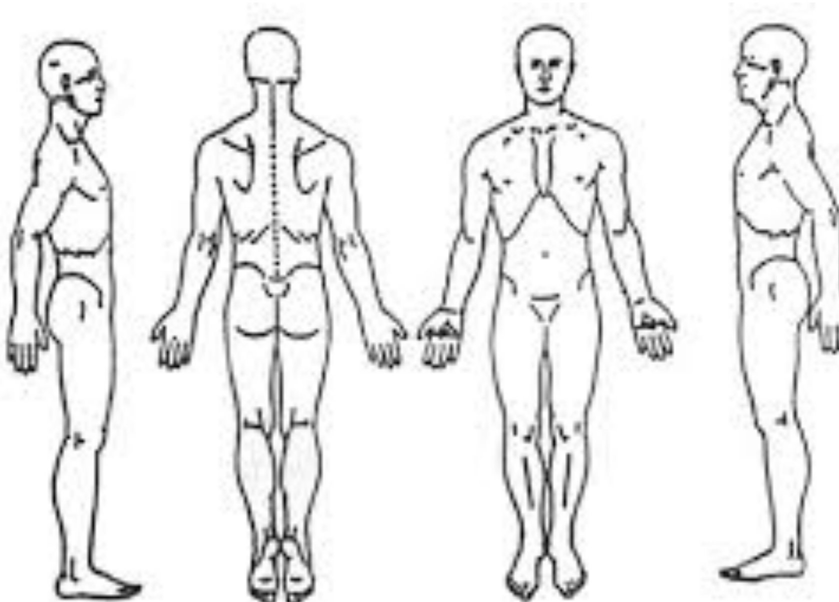
What makes your symptoms better? ____

What makes her symptoms worse? ____

Have you had this condition before? YES / NO

If yes, please explain: ____

Why do you feel this continues to happen to you? ____



Please indicate areas of concern on this diagram

Physical History and Lifestyle:

Please describe in detail including date(s) and severity of the following:

Falls/Impacts to your spine? ____

Broken bones? ____

Surgeries? ____

Motor Vehicle Collision? ____

Are you active in particular sports? Describe:______________________________

Do you exercise? DAILY / 2 -3x PER WEEK / 4 - 5 TIMES PER WEEK / MONTHLY / NEVER

Have you ever had physiotherapy? YES / NO Area of injury: ____________________

Are you currently taking any prescription or over-the-counter medication?
Please list names, frequency of use and condition taken for:

____

Are you currently taking any herbs, nutritional supplements, or natural remedies? Describe.

____

Daily water intake (cups): __________ Do you smoke? Y / N If yes, how much?__________

Please circle any conditions you currently suffer from. Please underline any past conditions.

CROHNS CANCER (Type: ____________) FIBROMYALGIA HIV / AIDS POLIO

COLITIS RHEUMATOID ARTHRITIS OSTEOARTHRITIS LUPUS FOOD INTOLERANCE

DIABETES MULTIPLE SCLEROSIS OSTEOPENIA SCOLIOSIS HIGH BLOOD PRESSURE

SHINGLES OSTEOPOROSIS HEART DISEASE GOUT LOSS OF SLEEP

HEPATITIS ANKYLOSING SPONDYLITIS HEARTBURN DEPRESSION

OTHER: ____

Please indicate any family history conditions (ex. Cancer, diabetes, heart attack, stroke, connective tissue disorders, arthritis, spinal conditions).

Father: ____

Mother:____

Brother(s): ____

Sister(s): ____

Have you ever received spinal adjustments by a Doctor of Chiropractic? YES / NO

Doctor's Name:______________________________ Date of Last Visit: ____________________

Reason for change/interruption of care: ____

Other doctor seen for this condition: ____

Please check (✓) any conditions that have occurred in the past 6 months. Please underline any symptoms that were a problem in the past 2 years.

	HEAD		**NECK**
	Headache		Pain with movement
	Migraine		Pain with turning
	Head feels heavy		Pain looking up
	Memory Loss		Pain looking down
	Fainting		Pinched nerve
	Blurred Vision		Neck feels out of place
	Light Sensitivity		Muscle Spasms
	Dizziness		Grinding or popping
	Pain in Ears		Arthritis
	Loss of balance		
	Loss of taste		**SHOULDERS**
	Loss of hearing		Pain in joints (LEFT / RIGHT)
			Pain across shoulders
	MID BACK		Unable to raise arm overhead
	Pain between shoulder blades		Unable to raise arm above shoulder
	Rib pain		Rotator cuff tear
	Muscle spams		Muscle spasms
	Kidney area pain		Pinched nerve
			Tension in shoulders

	LOW BACK		ARMS & HANDS
	Low back pain (LEFT / RIGHT)		Pain in elbows (LEFT / RIGHT)
	Central low back pain		Pain in hands (LEFT / RIGHT)
	Tailbone Pain		Numbness
	History of Disc Bulge / Herniation		Tingling
	Pain with cough, sneeze or bowel movement		Cold hands
	Muscle Spasms		Loss of grip strength
	Arthritis		Swollen joints in fingers
	Slipped Disc		Arthritis
	Low back feels out of place		Wrist pain (LEFT / RIGHT)
	HIPS, LEGS & FEET		**CHEST**
	Pain in buttocks (LEFT / RIGHT)		Chest pain
	Pain in hip joint (LEFT / RIGHT)		Breast pain
	Pain down the leg (LEFT / RIGHT)		Shortness of breath
	Knee pain (LEFT / RIGHT)		Rib pain
	Leg cramps		Irregular heartbeat
	Foot cramps		
	Numbness		**ABDOMEN**
	Tingling		Nausea
	Swelling in legs / feet		Vomiting
			Constipation
			Diarrhea
			Hemorrhoids
			Heartburn
			Poor Digestion
			Gallbladder