CONFIDENTIAL HEALTH RECORD

NAME _____ Date _____

CURRENT HEALTH CONDITIONS

Major Complaint: _____

_____

Where specifically does this cause you pain or discomfort: _____

When did it begin: _____

Was there a specific mechanism of injury that brought on the pain/condition? _____

Was on set of pain: Sudden Gradual

Has it occurred before: Yes No If yes when: _____

How long have you had this current episode of pain: _____

How often are the complaints/pain present? __Constant 75-100% __Frequent 50-74%
__Occasional 25-49% __Intermittent 25% or less

Have you had prior or current treatment for this condition: _____

What was successful and what did not help: _____

What is the quality of the pain: _____

Is the condition getting worse: _____

Is the condition interfering with your: Work Sleep Daily Routine (circle all that apply)

What activities are you unable to do now that you previously were able to do: _____

_____

Does this condition wake you at night: Yes No Sometimes

Is the pain localized or does it radiate to another area: _____

What aggravates your condition: _____

What relieves your condition: _____

Are you wearing any orthotics or heel lifts Yes No If yes, how long:

Other doctors seen for this condition: _____

Type of treatment received: _____

List all medications (prescriptions or over the counter) you are taking: _____

_____

HEALTH HISTORY

Have you had chiropractic care before? Yes No

Chiropractor's name: _____

Date of last visit: _____

List any other medical doctors you are seeing: _____

_____

PERSONAL HISTORY

Have you ever been in an automobile accident? Yes No

If yes, list dates and injuries: _____

_____

Have you every broken any bones? Yes No

If yes, list which ones where and when: _____

_____

Have you had any bad falls, sprains, strains, or stitches in the past? Yes No

Details: _____

Have you ever had x-rays of your neck or spine? Yes No

If yes, when: _____

Can you get a copy of them for our office?

Did you use ice or heat on the painful area? (Circle the one that applies, if any)

FAMILY HISTORY

Check any of the following conditions found in your family and state person's relationship to your beside it. (Ex: mother, brother, aunt)

_____ Cancer _____
_____ Diabetes _____
_____ Hypertension _____
_____ Heart attack _____
_____ Heart disease _____

_____ Kidney disease _____
_____ Stroke _____
_____ Thyroid disease _____
_____ Tuberculosis _____
_____ Others _____

_____
Cell phone number

_____
Best phone number to reach you