Holistic Chiropractic & Wellness
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PATIENT INFORMATION

Name:_____ Date:_____

What You Prefer To Be Called: _____ Sex: [ ] M [ ] F Marital Status: [ ] M [ ] S [ ] D [ ] W

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile:_____ Social Security #:_____

Age:_____ Birthdate:_____ Emergency Contact:_____

Address:_____ City:_____ State:_____ Phone:_____

Email:_____ May we email you our wellness newsletter? [ ] Y [ ] N

Who may we thank for your first visit? Referred By:_____ OR [ ] Website [ ] Google [ ] Other

Occupation:_____ Employer:_____

Work Address:_____ Work Number:_____

Significant Other's Name:_____ Do you have children? [ ] Y [ ] N Ages:_____

EMPLOYER:

MEDICAL HISTORY AND SYMPTOM / PAIN INFORMATION

(Additional room provided to answer questions on the back of this form)

A. Reason for today's visit: [ ] work [ ] auto [ ] sports/competition [ ] trauma [ ] stress [ ] anxiety [ ] chronic [ ] other

B. Explain what happened:_____ ->

C. Please describe the pain intensity and its location on the included "Pain Diagram" page.

D. When did this condition begin? ___/___/___ Is it getting worse? [ ] Y [ ] N [ ] Constant [ ] Comes & Goes

E. Is this condition interfering with your: [ ] work [ ] sleep [ ] daily routine [ ] relationships Please explain _____ ->

F. Have you had this or similar conditions in the past? [ ] Y [ ] N Please explain_____ ->

G. Have you ever been treated by a Medical Physician for this condition? [ ] Y [ ] N If so, where_____ ->

H. Have you ever been treated by a Chiropractic Physician? [ ] Y [ ] N If so, for what_____ ->

I. Please list any falls, slips, concussions, or accidents you may have had with dates:_____ ->

J. Family Health History (genetics, your environment, epigenetics):_____ ->

K. The feet are the foundation of your body. Are you now wearing? [ ] heel lifts [ ] sole lifts [ ] inner soles

[ ] arch supports [ ] custom-made orthotics

SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS

[ ] High Blood Pressure
[ ] Cholesterol
[ ] Thyroid Imbalance
[ ] Insulin Resistance/Diabetes
[ ] Headaches: Migraine, Tension
[ ] Fibromyalgia
[ ] [ ] Weight gain/loss
[ ] Stress, Anxiety, Depression
[ ] Nightmares
[ ] Trauma: Physical/Emotional
[ ] Loss of Family Member/Friend
[ ] Insomnia
[ ] Mood Swings
[ ] Joint Pain
[ ] Posture
[ ] Fallen-arches
[ ] ADDICTIONS

A.

B.

C.

D.

E.

F.

G.

H.

I.

J.

K.

Name:_____ Health History Intake Form Date:_____

Email: _____ Phone: _____

What are your health goals?

☐ Remove Pain
☐ Gain More Energy/Stamina
☐ Restore Health/Reduce Illness
☐ Achieve Optimal Wellness

What are your top 3 health complaints?

1)_____
2)_____
3)_____

Question	Y N	Patient Comment	Practitioner Comment
Are you on a particular diet or currently restricting certain foods?	Y N		
Do certain foods upset your stomach or cause constipation, IBS, or headaches?	Y N		
Do you have certain food cravings?	Y N		
Do you get shaky or anxious between meals?	Y N		
Do you drink **less** than half your body weight in water oz daily? (ex: if you weigh 150 lbs, 75 oz would be your daily water intake)	Y N		
Do you drink soda, sports, or energy drinks?	Y N		
Do you chew gum, drink diet drinks or consume sugar-free foods?	Y N		
Have you ever been unconscious, had a concussion, whiplash, closed head injury?	Y N		
Do you get muscle cramps, "charley horses", or eye twitches?	Y N		
Do you frequently use Tylenol, Ibuprofen, or other pain relief medications? (How many milligrams? How often?)	Y N		
Have you taken fish oil & had difficulty keeping it down?	Y N		
Do you have indigestion, belching, gas or bloating?	Y N		
Do you typically go **more** than 24 hours **without** a bowel movement?	Y N		
Have you had any organs surgically removed or medically altered? (appendix, gallbladder, etc.)	Y N		
Have you gained more than 15 lbs in the past year?	Y N		
Do you grind your teeth while you sleep?	Y N		
Do you have trouble falling or staying asleep?	Y N		
Have you had an illness that you have not fully recovered from?	Y N		

Do you have a health diagnosis or are you concerned with any of the following:

☐ High Blood Pressure
☐ Cholesterol
☐ Insulin Resistance (Diabetes)
☐ Thyroid Imbalance
☐ Arthritis
☐ Fibromialgia
☐ Cardiovascular
☐ Migraines/Headaches
☐ Stress
☐ Other_____

Please list all medications, supplements, and herbs that you are currently taking:_____

_____
_____
_____
_____
_____

Is there anything else you think I should be aware of: _____

_____
_____
_____
_____

Patient #:_____

General Pain Disability Index Questionnaire

Name (please print):_____ **Date:**_____

Age:_____ **Date of Birth:**_____ **Occupation:**_____

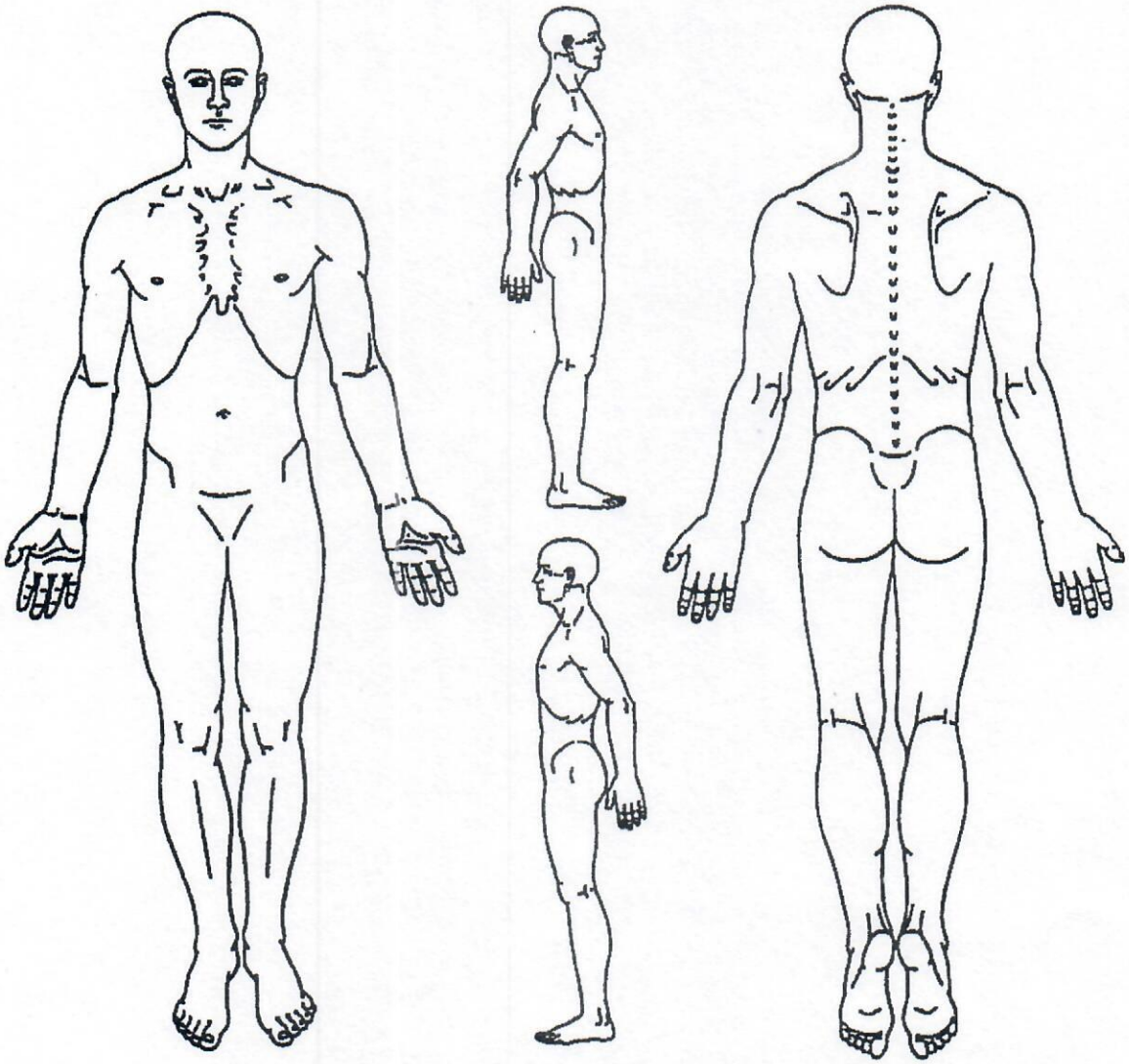
How long have you had this pain? _____Years _____Months _____Weeks

Is this your first episode of this pain? _____Yes _____No

Use the letters below to indicate the type and location of your sensations right now

Key:

A = Ache	B = Burning	N = Numbness
P = Pins & Needles	S = Stabbing	O = Others



For Doctor's Use:

Chief complaint (other than neck or low back pain):_____

DATE NAME: #

IMPORTANT: Please check (X) all present REVIEW OF SYMPTOMS

HEAD:
- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

SHOULDERS:
- ☐ Pain in shoulder joint (R - L)
- ☐ Pain across shoulders
- ☐ Bursitis (R - L)
- ☐ Arthritis (R - L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R - L)
- ☐ Muscle spasms in shoulders

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Numbness in arms (R - L)
- ☐ Numbness in fingers (R - L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

MID-BACK:
- ☐ Mid-back pain
- ☐ Location _____
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull Ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

ABDOMEN:
- Nervous stomach
- Foods can't eat _____
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK:
- Low back pain
  - Upper lumbar
  - Lower lumbar
  - Sacroiliac
- Low back pain is worse when:
  - working
  - lifting
  - stooping
  - standing
  - sitting
  - bending
  - coughing
  - lying down (sleeping)
  - walking
- Pain relieves when
- Slipped disk
- Low back feels out of place
- Muscle spasms
- Arthritis

HIPS, LEGS & FEET:
- Pain in buttocks (R - L)
- Pain in hip joint (R - L)
- Pain down leg (R - L)
- Pain down both legs
- Knee pain
  - Inside
  - Outside
- Leg cramps
- Cramps in feet (R - L)
- Pins & needles in legs (R - L)
- Numbness of leg (R - L)
- Numbness of feet (R - L)
- Numbness of toes
- Feet feel cold
- Swollen ankles (R - L)
- Swollen feet (R - L)

WOMEN ONLY:
- ☐ Menstrual pain _____ (where)
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle _____ days
- ☐ Birth control _____ (type)
- ☐ Hysterectomy
- ☐ Genital cancer _____
- ☐ Discharge
- ☐ Menopause _____
- ☐ Tumors
- ☐ Abortions
- ☐ Are you or do you think you are pregnant?

MEN ONLY:
- ☐ Urinary frequency
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostate pain/swelling

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep
- ☐ Loss of sleep _____ hrs /night
- Loss of weight _____ lbs.
- Gain weight _____ lbs
- ☐ Coffee _____ cups/day
- Tea _____ cups/day
- Cigarettes _____ pack/day
- Other _____
- Diabetes
- Hypoglycemia

REMARKS:

REV 11/94