National Pike CHIROPRACTIC

Patient History (Please Print)

Date: _____

Name: _____ **Email:** _____
Phone: (Home) _____ **(Mobile)** _____ **(Work)** _____
Address: _____ **City:** _____ **Zip:** _____
Birth Date:___/___/ ___ ☐ **Male** ☐ **Female** **Spouse/Parent Name:** _____
# of Children: _____ ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**
Are you Pregnant? ☐ **YES** ☐ **NO** **Due Date:**_____
Occupation: _____

How were you referred to our office? _____

If from the internet, name of search engine and key words used: _____
Have you ever had Chiropractic Care before? _____ **If yes, when?** _____

List your chief complaints in order of severity; Check all those that describe your condition:

Complaint 1: _____ For How Long? _____
What originally caused this problem? _____
Feels Like:
☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling
☐ Burning ☐ Other: _____
Bothers Me:
☐ Constant (100%) ☐ Frequent (50%-75%) ☐ Intermittent (25%-50%) ☐ Occasional (1%-25%)
It Has Been:
☐ Getting Worse ☐ Staying Same ☐ Getting Better
Pain Scale: (0=No Pain – 10=Severe Pain)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
During The Day It Is:
☐ Worse in the AM ☐ Stays the same throughout the day ☐ Worse in the PM
The Following Increases Pain:
☐ Moving ☐ Sitting ☐ Lifting ☐ Bending ☐ Walking ☐ Laying Down ☐ Other: _____
The Following Decreases Pain:
☐ Moving ☐ Sitting ☐ Lifting ☐ Bending ☐ Walking ☐ Laying Down ☐ Other: _____
Does The Pain Travel/Radiate? :
☐ Yes ☐ No If yes, where_____ to _____

Complaint 2: _____ For How Long? _____
What originally caused this problem? _____
Feels Like:
☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling
☐ Burning ☐ Other: _____
Bothers Me:
☐ Constant (100%) ☐ Frequent (50%-75%) ☐ Intermittent (25%-50%) ☐ Occasional (1%-25%)
It Has Been:
☐ Getting Worse ☐ Staying Same ☐ Getting Better
Pain Scale: (0=No Pain – 10=Severe Pain)
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During The Day It Is:
☐ Worse in the AM ☐ Stays the same throughout the day ☐ Worse in the PM
The Following Increases Pain:
☐ Moving ☐ Sitting ☐ Lifting ☐ Bending ☐ Walking ☐ Laying Down ☐ Other: _____
The Following Decreases Pain:
☐ Moving ☐ Sitting ☐ Lifting ☐ Bending ☐ Walking ☐ Laying Down ☐ Other: _____
Does The Pain Travel/Radiate?
☐ Yes ☐ No If yes, where_____ to _____

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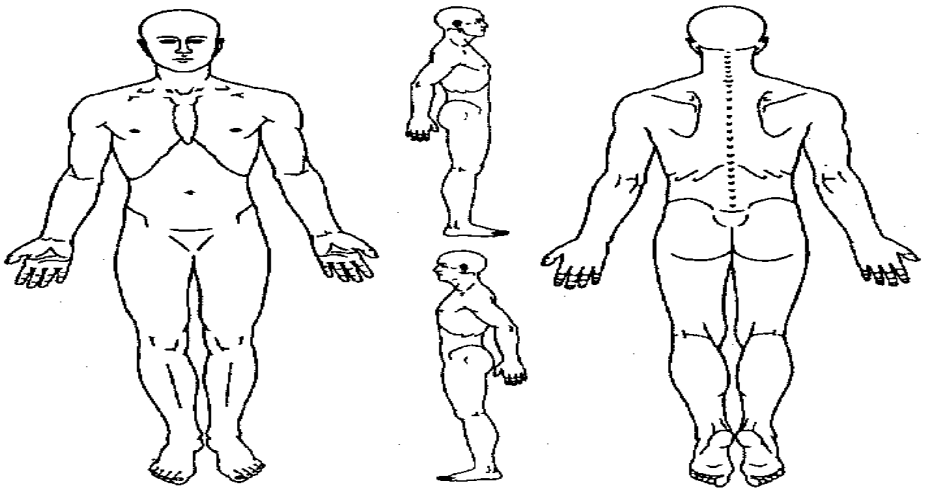
Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels. Include all affected areas.



Does your condition interfere with you:

Work	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE
Sleep	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE
Daily Routine	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE
Recreation	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE

Family History (please list all known conditions/illnesses that may apply):

Mother: _____ Father: _____

Grandparents: _____ Siblings: _____

Other known familial conditions: _____

List other doctors consulted for condition:

1: _____ 2: _____

3: _____ 4: _____

List of Current Medications/Supplements:

_____

_____

_____

List of Previous Hospital Stays/Surgeries:

_____

_____

_____

List of Any Childhood Traumas / Past Accidents / Falls / Auto Injuries:

_____

_____

Is there anything else you think we should know about or that you would like to discuss? (Explain):

_____

_____

Health History (Check if you have ever had any of the following:)		
☐ Abdominal Aortic Aneurysm	☐ Emphysema	☐ Multiple Sclerosis
☐ Acid Reflux	☐ Epilepsy	☐ Mumps
☐ AIDS/HIV	☐ Erectile Dysfunction	☐ Neck Pain
☐ Alcoholism	☐ Eye Troubles	☐ Osteoporosis
☐ Allergies	☐ Fractures	☐ Pacemaker
☐ Allergy Shots	☐ Glaucoma	☐ Parkinson's
☐ Anemia	☐ Goiter	☐ Pinched Nerve
☐ Anorexia	☐ Gonorrhea	☐ Pneumonia
☐ Anxiety	☐ Gout	☐ Prostate Problems
☐ Appendicitis	☐ Headaches	☐ Psychiatric Care
☐ Arthritis	☐ Heart Disease	☐ Rheumatoid Arthritis
☐ Asthma	☐ Heart Issues	☐ Shortness of Breath
☐ Bleeding Disorders	☐ Hepatitis	☐ Stroke
☐ Bulimia	☐ Hernia	☐ Suicide Attempt
☐ Burning Feet	☐ Herniated Disc	☐ Swollen Ankles
☐ Buzzing/Ringing in Ears	☐ Herpes	☐ Throat Conditions
☐ Cancer	☐ High Cholesterol	☐ Thyroid Conditions
☐ Cataracts	☐ Hip Pain	☐ Tuberculosis
☐ Chemical Dependency	☐ Hypertension/ HBP	☐ Tumors/Growths
☐ Chicken Pox	☐ Indigestion	☐ Typhoid Fever
☐ Chronic Bronchitis	☐ Infertility	☐ Ulcers
☐ Chronic Fatigue	☐ Insomnia	☐ Unexplained Memory Loss
☐ Chronic Sinus Infections	☐ Kidney Disease	☐ Unexplained Weight Loss
☐ Chronic Tonsillitis	☐ Kidney Stones	☐ Unexplained Weight Gain
☐ Constipation	☐ Leg Pain	☐ Upper Back Pain
☐ Coronary Artery Disease	☐ Liver Disease	☐ UTI
☐ Depression	☐ Low Back Pain	☐ Vaginal Infections
☐ Diabetes	☐ Measles	☐ Venereal Disease
☐ Diarrhea	☐ Menstrual Problems	☐ Vertigo
☐ Difficulty Swallowing	☐ Mid Back Pain	☐ Whooping Cough
☐ Digestive Problems	☐ Migraines	☐ Other:_____
☐ Dysmenorrhea	☐ Miscarriage	
☐ Eczema	☐ Mononucleosis	

Lifestyle

Exercise	**Work Activity**	**Habits**
___None	___Sitting	___Smoking ____ packs per day
___Moderate	___Standing	___Chewing Tobacco ____ cans per day
___Daily	___Light Labor	___Caffeine ____ cups per day
___Heavy	___Heavy Labor	___Alcohol ____ drinks per day

Briefly describe exercise routine (if any): _____

_____

Briefly describe work labor (if applicable): _____

_____

History of drug use (circle one): Yes No

Patient's Signature: _____ **Date:** _____

***** If you have insurance please give the front desk your card *****

Doctor's Signature: _____ **Date:** _____