National Pike CHIROPRACTIC

Patient History (Please Print)

Date: _____

A. Personal Identifying Information

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:_____
Emergency Contact: _____ Emergency Contact #: _____

B. 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? _____

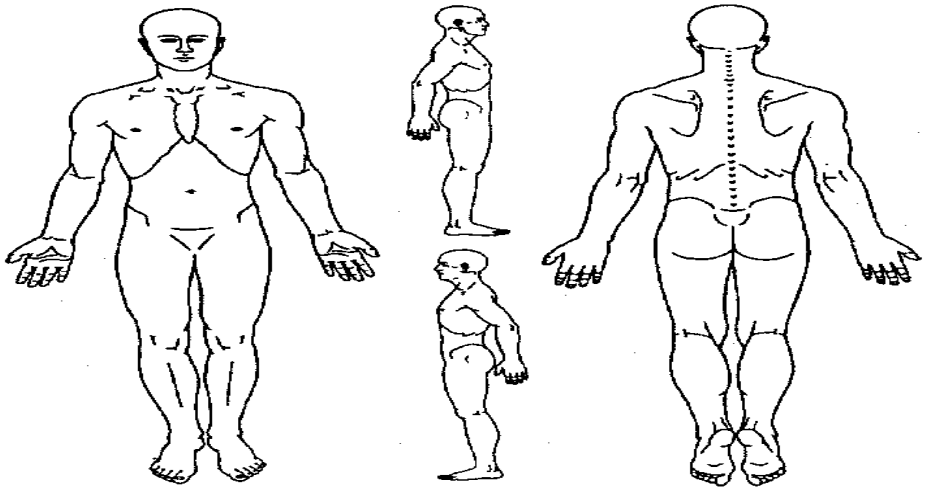
C. Lifestyle Information:
Occupation: _____
Work/Home Demands *(check which applies)*
☐ Sit All Day (75-100%) ☐ Sit Occasionally (25-49%)
☐ Sit Frequently (50-74%) ☐ Never Sit (0-24%)

Lift 0-25lbs	☐ Frequent	☐ Occasional	☐ Never
Lift 26-50lbs	☐ Frequent	☐ Occasional	☐ Never
Lift 50+lbs	☐ Frequent	☐ Occasional	☐ Never

Leisure Activities: _____
Exercise: Y / N Explain: _____
Function Limitations of Current Problem: _____
_____

Habits:
Current Smoker? Y / N If so, how many packs per day: _____
Quit Smoking? Y / N If so, how long since you quit? _____
Chew Tobacco: Y / N If so, how many per day? _____
Caffeine? Y / N If so, how many cups per day? _____
Alcohol? Y / N If so, avg drinks per week? _____
History of Drug Use? Y / N

D. Mark an "X" on the areas you feel pain. Mark an "N" for numbness. Mark a "T" for tingling.
Draw an arrow if the pain travels. Include all affected areas.



X = pain
N = numbness
T = Tingling

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E. Personal Health History

List other doctors consulted/treatment rendered for condition:

1: _____ 2: _____

3: _____ 4: _____

Previous Spinal Pain History:

_____

_____

Injury History:

_____

_____

Medications:

_____

_____

History of Cancer? Y / N _____ **Recent Surgery: Y / N** _____

Bowel / Bladder Function: Normal / Abnormal **Unexplained Weightloss: Y / N** _____

History of Trauma/Auto Accident? Y / N _____

_____

Previous Hospital Stays: Y / N:

_____

_____

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

Mother: _____ Father: _____

Grandparents: _____ Siblings: _____

Other known familial conditions: _____

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	☐ Mumps
☐ Acid Reflux	☐ Epilepsy	☐ Neck Pain
☐ Alcoholism	☐ Erectile Dysfunction	☐ Osteoporosis
☐ Allergies	☐ Eye Issues	☐ Pacemaker
☐ Anemia	☐ GI Issues	☐ Pinched Nerve
☐ Anorexia	☐ Gout	☐ Pneumonia
☐ Anxiety	☐ Headaches / Migraines	☐ Prostate Problems
☐ Appendicitis	☐ Heart Attack	☐ Psychiatric Care
☐ Arthritis	☐ Heart Issues	☐ Rheumatoid Arthritis
☐ Asthma	☐ Hepatitis	☐ Ringing in the ears
☐ Bleeding Disorders	☐ Hernia	☐ Shortness of Breath
☐ Bulimia	☐ High Cholesterol	☐ Skin issues
☐ Chemical Dependency	☐ Hypertension/ HBP	☐ Stroke
☐ Chronic Bronchitis	☐ Infertility	☐ Swollen Ankles
☐ Chronic Fatigue	☐ Insomnia	☐ Throat Conditions
☐ Chronic Sinus Infections	☐ Kidney Issues	☐ Thyroid Conditions
☐ Chronic Tonsillitis	☐ Leg Pain	☐ Tumors/Growths
☐ COPD	☐ Liver Disease	☐ Ulcers
☐ Depression	☐ Measles	☐ Unexplained Memory Loss
☐ Diabetes	☐ Menstrual Problems	☐ UTI
☐ Difficulty Swallowing	☐ Mononucleosis	☐ Venereal Disease
☐ Digestive Problems		☐ Vertigo
Other:_____		☐ Whooping Cough

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

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