



Patient History

NAME: _____ E-MAIL: _____ DATE: _____
 DOB: _____ PHONE #: _____
 WHO REFERRED YOU TO OUR OFFICE: _____

What brings you into our office today?

Have you tried other therapies? Yes _____ No _____
 If yes, which ones?

Why did they work / not work? _____
 What do you expect from Chiropractic / Applied Kinesiology care?

What are your health care goals? _____ Get rid of pain _____ Improve function
 _____ Prevent injury / disease _____ Nutrition / Weight Loss _____ Wellness

- Do you have vertigo (dizziness)? Yes _____ No _____
- Do you pass out easily (faint or loss of consciousness)? Yes _____ No _____
- Do you have double vision or have you lost sight in one eye? Yes _____ No _____
- Do you have any slurred speech or difficulty with speech? Yes _____ No _____
- Do you have indigestion or difficulty swallowing? Yes _____ No _____
- Do you have any difficulty walking, with coordination or falling to one side? Yes _____ No _____
- Do you have nausea or vomiting? Yes _____ No _____
- Do you have numbness on one side of your face or body? Yes _____ No _____
- Do you have any visual disturbances or rapid eye movement? Yes _____ No _____
- Do you have or have you ever had difficulty in arranging words properly? Yes _____ No _____
- Do you have a headache or head pain that is unlike any you have had before? Yes _____ No _____
- Do you have headaches for hours or days? Yes _____ No _____
- Do you have a history of stroke in your family? Yes _____ No _____
- Do you have chest pain? Yes _____ No _____
- Do you have any change in bowel or bladder habits? Yes _____ No _____
- Do you have a sore that does not heal? Yes _____ No _____
- Do you have any unusual bleeding or discharge? Yes _____ No _____
- Do you have any thickening in your breasts or elsewhere? Yes _____ No _____
- Do you have a change in any wart or mole? Yes _____ No _____
- Do you have a nagging cough or hoarseness? Yes _____ No _____
- Do you have night sweats? Yes _____ No _____
- Do you have pain in neck, jaw or face? Yes _____ No _____
- Do you have a drooping eyelid or change in your pupils? Yes _____ No _____
- Do you have any ringing in your ears? Yes _____ No _____
- (Women Only)** Do you take birth control pills? Yes _____ No _____

What prescription medication are you taking if any?

- High blood pressure _____
- Blood thinners _____
- Other _____

- Have you ever had cancer? Yes ___ No ___
- Does you pain ever wake you from a sound sleep? Yes ___ No ___
- Are you losing weight now without trying? Yes ___ No ___
- Are you coughing up blood or noticing it in your stools or urine? Yes ___ No ___
- Have you had any loss of bladder or bowel control? Yes ___ No ___
- Have you lost consciousness or had double vision recently? Yes ___ No ___
- Are you seeing another doctor now for any reason? Yes ___ No ___

Note: _____

Are you taking any over-the-counter drugs? Yes ___ No ___

Please indicate (aspirin, etc.) _____

Are you taking herbs, nutraceuticals, botanicals, or vitamins?

Please list _____

(Women only) What was the date of onset of your last menses? _____

Social History

SMOKER _____ Yes or _____ No, If Yes, how many packs _____

ALCOHOL _____ Yes or _____ No, If Yes, how much _____

Family History

Does your family have a history of the following:

M = Mother, **F** = Father, **GM** = Grandmother, **GF** = Grandfather, **B** = Brother, **S** = Sister, **Y** = self.

- High Blood Pressure
- Heart Attack
- Emphysema
- Seizure-Convulsions
- HIV Positive
- Asthma
- Diabetes
- Kidney Disease
- Ulcer or Stomach Problems
- Stroke (Please indicate age when stroke occurred, Mother _____ Father _____)
- Arthritis-Rheumatism
- Mental Illness
- Thyroid Disease
- Circulation Problems
- Cancer

Review of Systems

