

GENERAL HISTORY FORM

DATE _____	HEIGHT _____ WEIGHT _____
NAME _____	BIRTHDATE _____ SEX: M / F
ADDRESS _____	MARITAL STATUS: S / M / D / W
CITY/STATE/ZIP _____	EMPLOYER _____
PHONE (HOME) _____	OCCUPATION _____
PHONE (CELL) _____	DO YOU HAVE INSURANCE? YES / NO
E-MAIL _____	SSN _____

PLEASE CHECK HOW YOU HEARD ABOUT OUR OFFICE:

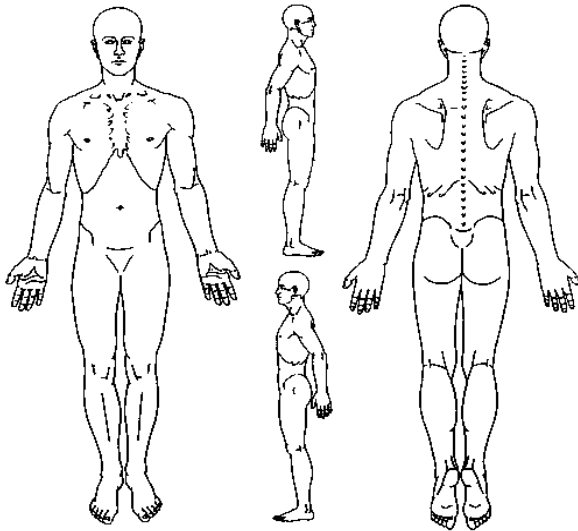
COFFEE SOCIAL REFERRAL FROM: _____ WEBSITE/INTERNET ADVERTISEMENT OTHER

PLEASE CHECK WHICH SERVICES YOU ARE HERE TO RECEIVE:

CHIROPRACTIC SPINAL DECOMPRESSION NUTRITIONAL ADVICE ACUPUNCTURE
 PERSONAL TRAINING / REHAB WHATEVER IS RECOMMENDED

ON THE DIAGRAM BELOW, PLEASE SHOW WHERE YOU ARE EXPERIENCING ALL OF YOUR PRESENT COMPLAINTS:

A=ACHE B=BURNING C=CRAMPING D=DULL R=THROBBING N=NUMB T=TINGLING



OF THE ABOVE SYMPTOMS WHICH ONE IS YOUR MAIN CONCERN? _____

WHEN DID YOU FIRST NOTICE THIS PROBLEM? _____

WAS IT CAUSED BY: AUTO ACCIDENT ON-THE-JOB INJURY OTHER

DESCRIBE _____

HAVE YOU BEEN TREATED FOR THIS CONDITION? YES NO

IF YES, WHEN? _____ FOR HOW LONG? _____

BY WHOM? _____ RESULTS? _____

ON THE SCALE BELOW, PLEASE CIRCLE THE SEVERITY OF YOUR MAIN COMPLAINT.

NONE	SLIGHT	MILD	MODERATE	SEVERE
0	1 2 3	4 5	6 7 8	9 10

ON THE SCALE BELOW, PLEASE CIRCLE THE PERCENTAGE OF TIME YOU EXPERIENCE YOUR MAIN COMPLAINT.

OCCASIONAL	INTERMITTENT	FREQUENT	CONSTANT
0	25	50	75 100

WHEN DO YOU NOTICE IT MOST? AM PM HAVE YOU EVER HAD THIS PROBLEM IN THE PAST? YES NO

WHAT MAKES IT FEEL BETTER? _____

WHAT MAKES IT FEEL WORSE? _____

GENERAL HISTORY FORM

PATIENT NAME: _____ DATE: _____

DO YOU HAVE ANY PAIN/DIFFICULTY PERFORMING ANY OF THE FOLLOWING ACTIVITIES?

____ PERSONAL CARE	____ LIFTING	____ READING	____ STANDING	____ SOCIAL LIFE
____ SLEEPING	____ WALKING	____ CONCENTRATING	____ SITTING	____ RECREATION
____ TURNING	____ CLIMBING STAIRS	____ DRIVING	____ WORKING	____ OTHER

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTIC DOCTOR? ____ YES ____ NO

IF YES, WHOM? _____ WHEN? _____
RESULTS AND IMPRESSIONS? _____

HAVE YOU EVER BEEN TREATED BY AN ACUPUNCTURIST? ____ YES ____ NO

IF YES, WHOM? _____ WHEN? _____
RESULTS AND IMPRESSIONS? _____

ARE YOU CURRENTLY BEING TREATED BY ANOTHER DOCTOR? ____ YES ____ NO

IF YES, WHOM? _____ WHY? _____

ARE YOU CURRENTLY TAKING ANY OVER-THE-COUNTER OR PRESCRIPTION MEDICATION? ____ YES ____ NO

IF YES, WHAT AND WHY? (please ask for additional pages if you need more room) _____

PREVIOUS ILLNESSES, INJURIES, HOSPITALIZATIONS AND OPERATIONS (please ask for additional pages if you need more room)

AREA OF BODY/SYMPTOMS	DATE	DESCRIBE (INCLUDE ANY MEDICATIONS)
_____	_____	_____
_____	_____	_____
_____	_____	_____

SYSTEM REVIEW (HAVE YOU EVER HAD ANY OF THE FOLLOWING, CIRCLE YES OR NO FOR EACH)

Y N LUNG DISEASE	Y N HIGH CHOLESTEROL	Y N URINARY PROBLEMS	Y N CANCER	Y N CHRONIC FATIGUE SYNDROME
Y N ASTHMA	Y N HIGH/LOW BLOOD PRESSURE	Y N KIDNEY PROBLEMS	Y N MENTAL ILLNESS	Y N FIBROMYALGIA
Y N ALLERGIES	Y N HEART ATTACK	Y N OSTEOPOROSIS	Y N DEPRESSION	Y N IRRITABLE BOWEL SYNDROME
Y N SKIN PROBLEMS	Y N STROKE	Y N OSTEOARTHRITIS	Y N INSOMNIA	Y N HYPER/HYPO THYROID
Y N VISION PROBLEMS	Y N HEARING PROBLEMS	Y N RHUEMATOID ARTHRITIS	Y N HEPATITIS	Y N DIABETES
Y N HEART DISEASE	Y N DIFFICULTY GAINING WEIGHT	Y N SCOLIOSIS	Y N HIV POSITIVE / AIDS	Y N EPILEPSY
Y N VARICOSE VEINS	Y N DIFFICULTY LOSING WEIGHT	Y N DISC PROBLEMS	Y N WATER RETENTION	Y N OTHER: _____
Y N BLOOD CLOTS	Y N GALL BLADDER PROBLEMS	Y N BROKEN BONES	Y N LIVER PROBLEMS	

(WOMEN ONLY)

Y N CURRENTLY PREGNANT	Y N SEVERE PMS	Y N MENOPAUSE	Y N LUMPS IN BREAST
Y N ORAL CONTRACEPTIVE USE	Y N SEVERE MENSTRUAL CRAMPS	Y N HYSTERECTOMY	Y N OTHER: _____

(MEN ONLY)

Y N PROSTATE PROBLEMS	Y N DIFFICULT URINATION	Y N TESTICULAR PAIN	Y N OTHER: _____
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FAMILY HISTORY (HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING, CIRCLE YES OR NO FOR EACH)

Y N LUNG DISEASE	Y N HEART ATTACK	Y N LIVER PROBLEMS	Y N DIABETES
Y N HEART DISEASE	Y N STROKE	Y N KIDNEY PROBLEMS	Y N THYROID DISORDER
Y N HIGH CHOLESTEROL	Y N MENTAL ILLNESS	Y N ARTHRITIS	Y N CANCER
Y N HIGH BLOOD PRESSURE	Y N GALL BLADDER PROBLEMS	Y N EPILEPSY	Y N OTHER: _____

SOCIAL HISTORY

DO YOU SMOKE? ____ YES ____ NO DO YOU EXERCISE? ____ YES ____ NO DESCRIBE: _____
EVALUATE YOUR STRESS LEVEL: ____ SEVERE ____ MODERATE ____ MINIMAL ____ NONE
DO YOU TAKE A MULTI-VITAMIN/MINERAL SUPPLEMENT DAILY? ____ YES ____ NO OTHER NUTRITIONAL SUPPLEMENTS? ____ YES ____ NO

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE