



Health by Hands CHIROPRACTIC

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Confidential Patient Information

Name: _____ Date of Birth ____/____/____ Age ____ Sex: M F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Would you like to receive office communication via email? Yes No

Marital Status M D S W Spouse Name _____ #Children _____

Occupation _____ Employer _____ School _____

Emergency Contact Name _____ Emergency Contact Phone Number _____

Primary Care Doctor _____ Phone Number _____ May we contact them? Yes No

Health Insurance Company _____ Phone Number _____ ID _____

Group Number _____ Insured's Name _____ Insured's Date of Birth ____/____/____

Main Complaint: _____

Are your current problems due to an injury? Yes No Date of injury ____/____/____

If yes, was the injury On the job At work If yes, has this incidence been reported? Yes No

Is the injury case still open? Yes No Have you retained an attorney Yes No

If yes, attorney name _____

How did you hear about our office? _____

Why did you come into our office and what is your expectation of us? _____

How would you like us to handle your problem? Maximum Correction OR Temporary Relief

Had past chiropractic care? Yes No When? _____ Had spinal x-rays in the last year? Yes No

Please list all surgeries, falls, auto accidents and injuries (regardless how severe) with dates _____

Medications:

Please list all prescription, over the counter medications or nutritional supplements you are taking

Name	Purpose	Dosage

Please list all known allergies _____

HEALTH HISTORY – Please mark all that apply (past or present)

General Systems

- Cancer
- Diabetes
- Headache
- Epilepsy
- Hernia
- Loss of Sleep/Fatigue
- Stroke
- Dizziness/Vertigo

Gastrointestinal

- Heartburn/Reflux
- Constipation
- Diarrhea
- Excessive hunger/thirst

Spine/Extremity

- Herniated Disc
- Neck pain R/L
- Jaw pain/click R/L
- Mid back pain R/L
- Low back Pain R/L
- Numbness/tingling R/L in arms/legs
- Shoulder pain R/L
- Elbow pain R/L
- Wrist/Hand pain R/L
- Hip pain R/L
- Knee pain R/L
- Ankle/Foot pain R/L

Miscellaneous

- Night Pain
- Pain that wakes you up from sleep
- Unexplained weight loss/gain

Genito-Urinary

- Blood in urine
- Frequent urination
- Changes in bowel/bladder function

Cardiovascular

- Shortness of breath
- High/Low Blood Pressure
- Light headed (positional)
- Pacemaker
- Heart attack
- High cholesterol
- Chest pain

Respiratory

- Allergy
- Asthma
- Chronic Cough

Skin

- Eczema/Psoriasis
- Bruise easily
- Hives

Women only

- Birth control
- Breast Implant
- Pregnant Unsure
- Not pregnant
- Painful Periods
- Irregular Periods

Social History

- Smoking: packs/day
- Never Smoker
- Former Smoker

Number caffeinated beverages per day _____ Exercise type and frequency: _____

Number alcoholic beverages per week _____ Do you use recreational drugs? _____

Family History

	Diabetes	Heart Disease	Cancer	Hypertension
Parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandparent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please circle area and type of pain on the drawings using the codes listed below

- | | |
|----------------|--------------------|
| N - Numbness | TH - Throbbing |
| P - Pain | MSP - Muscle Spasm |
| SH - Sharp | SHO - Shooting |
| T - Tingling | B - Burning |
| A - Ache | C - Cramps |
| D - Dull | SW - Swelling |
| S - Soreness | O - Other |
| ST - Stiffness | |



BELOW: list your symptoms, from most severe to mildest, and include ANY and ALL areas that bother you including knees, shoulders, hands, feet, ear infections, headaches, jaw, etc.

Worst symptom: _____ What happened? _____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 When did the pain start? _____

Quality of pain (circle all that apply): sharp shooting dull ache burning stabbing stiff throbbing numbness

Does your pain radiate into arms? Y N Legs? Y N

Worse with (circle all that apply): sitting standing walking bending lifting other: _____

Better with (circle all that apply): rest ice heat stretching exercise pain relievers topical creams other: _____

Worse during (circle): morning afternoon evening during sleep

What treatment have you received for this condition (circle): medication physical therapy surgery other: _____

List any area of your life affected by this complaint (ex: work, home, kids, hobbies, etc) 1. _____
 2. _____
 3. _____

Symptom 2: _____ What happened? _____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 When did the pain start? _____

Quality of pain (circle all that apply): sharp shooting dull ache burning stabbing stiff throbbing numbness

Does your pain radiate into arms? Y N Legs? Y N

Worse with (circle all that apply): sitting standing walking bending lifting other: _____

Better with (circle all that apply): rest ice heat stretching exercise pain relievers topical creams other: _____

Worse during (circle): morning afternoon evening during sleep

What treatment have you received for this condition (circle): medication physical therapy surgery other: _____

List any area of your life affected by this complaint (ex: work, home, kids, hobbies, etc) 1. _____
 2. _____
 3. _____