



**Patient History Form**

Today's Date: \_\_\_\_\_ Sex: M F Birth date: \_\_\_\_\_ SS# \_\_\_\_\_  
Month Day Year

Name \_\_\_\_\_ Refer to me as: \_\_\_\_\_  
FIRST MIDDLE LAST

Circle: Single Married Separated Divorced Widowed Other

How did you hear about *Northwest Spine Clinic*? \_\_\_\_\_

Business/Employer \_\_\_\_\_ Type of Work \_\_\_\_\_ Years \_\_\_\_\_

Home Address \_\_\_\_\_  
STREET CITY & STATE ZIP

Email \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Dr and/or staff may contact me at work? YES NO Work Phone \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Age \_\_\_\_\_  
FIRST MIDDLE LAST

**CURRENT HEALTH STATUS**

My main health concerns/symptoms are:	Duration (minutes, hours, days, weeks)	When or what time of day is it worse?	Intensity (on a scale of 1-10)	How would you describe the pain?
1.				
2.				
3.				
4.				

*Doctor's Notes:*

What do you think caused your concerns and symptoms?

Sports-related     Job-related     Auto accident     Unsure     Other

Injury Date \_\_\_\_\_ Please specify *Other* \_\_\_\_\_

Have you had this before?     Yes     No     Unsure    If yes, when? \_\_\_\_\_

What makes it worse? \_\_\_\_\_ What makes it better? \_\_\_\_\_

What things can you not do because of your condition(s)? \_\_\_\_\_

Have you seen other doctors or therapists for this?     Yes     No

If yes, name of doctor: \_\_\_\_\_ Type of doctor: \_\_\_\_\_

When: \_\_\_\_\_ Where: \_\_\_\_\_

Type of care given: \_\_\_\_\_ Diagnosis given: \_\_\_\_\_

Did you find it effective?     Yes     No     Unsure

Was your care     Complete     Incomplete     Still occurring     Unsure

Have you ever consulted a professional for nutritional advice?     Yes     No

If you are presently taking any medication or vitamins, please list their names and purpose:

	<u>Name</u>	<u>Purpose</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

*Doctor's Notes:*

## YOUR PAST GENERAL HEALTH

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following diseases you have had or still have:

- |   |   |                                    |  |  |
|---|---|------------------------------------|--|--|
| <input type="checkbox"/> Pneumonia      | <input type="checkbox"/> Mumps                  | <input type="checkbox"/> Influenza | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Shingles        |
| <input type="checkbox"/> Small Pox      | <input type="checkbox"/> Pleurisy               | <input type="checkbox"/> Polio     | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Aids/HIV        |
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Psoriasis       |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Mental Disorder        | <input type="checkbox"/> Anemia    | <input type="checkbox"/> Thyroid             | <input type="checkbox"/> Eczema          |
| <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Low Back Pain          | <input type="checkbox"/> Measles   | <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Hepatitis (Type _____) |                                    | <input type="checkbox"/> Cancer (Type _____) |  |
- When \_\_\_\_\_

*Doctor's Notes:*

Check any of the following that you have on a **regular** basis, **especially during the last 6 months:**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Neck Pain             | <input type="checkbox"/> Pins & Needles in Arms/Hands | <input type="checkbox"/> Gall Bladder Trouble | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Fainting                     | <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Constipation           |
| <input type="checkbox"/> Shooting Head Pains   | <input type="checkbox"/> Loss of Balance              | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Kidney Trouble         |
| <input type="checkbox"/> Sinus Trouble         | <input type="checkbox"/> Ringing in Ears              | <input type="checkbox"/> Low Blood Pressure   | <input type="checkbox"/> Menstrual Cramps       |
| <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Wear Glasses / Contacts      | <input type="checkbox"/> Nervous Stomach      | <input type="checkbox"/> Diarrhea               |
| <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Lights Bother Eyes           | <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Painful/Swollen Joints |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Muscle Spasms in Neck        | <input type="checkbox"/> Depression           | <input type="checkbox"/> Chronic Colds/Flu      |
| <input type="checkbox"/> Loss of Taste         | <input type="checkbox"/> Grating in Neck              | <input type="checkbox"/> Inner Tension        | <input type="checkbox"/> Slipped Disc           |
| <input type="checkbox"/> Tightness of Throat   | <input type="checkbox"/> Tightness of Shoulder        | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Pinched Nerves in Back |
| <input type="checkbox"/> Throat Inflammation   | <input type="checkbox"/> Cold Hands                   | <input type="checkbox"/> Cold Sweats          | <input type="checkbox"/> Pins & Needles in Legs |
| <input type="checkbox"/> Face Flushed          | <input type="checkbox"/> Chest Pains                  | <input type="checkbox"/> Liver Trouble        | <input type="checkbox"/> Swollen Ankles         |
| <input type="checkbox"/> Twitching of the Face | <input type="checkbox"/> Shortness of Breath          | <input type="checkbox"/> Indigestion          | <input type="checkbox"/> Cold Feet              |
| <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Heart Pain                   | <input type="checkbox"/> Intestinal Gas       | <input type="checkbox"/> Pains in Legs & Feet   |
| <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Heart Palpitation            | <input type="checkbox"/> Low Back Pain        | <input type="checkbox"/> Sleeping Problems      |
| <input type="checkbox"/> Head Feels too Heavy  | <input type="checkbox"/> Mid Back Pain                | <input type="checkbox"/> Scoliosis            | <input type="checkbox"/> Seizures               |
| <input type="checkbox"/> Allergies             | <input type="checkbox"/> TMJ                          | <input type="checkbox"/> Hot Flashes          | <input type="checkbox"/> Weight Gain/Loss       |

*Doctor's Notes:*

## PAST ACCIDENTS / INJURIES / SURGERIES

Have you had any car accidents?      Yes    No    When? \_\_\_\_\_  
Have you had any serious injuries?    Yes    No    Type \_\_\_\_\_      When? \_\_\_\_\_  
Have you broken any bones?            Yes    No    Which? \_\_\_\_\_      When? \_\_\_\_\_  
Have you had any major surgery?      Yes    No    Type? \_\_\_\_\_      When? \_\_\_\_\_  
Have you had any recent tests: XRAYs, MRI, CT SCANS, NCV, EMG (circle if yes)

*Doctor's Notes:*

## HABITS

**Alcohol**, Usual type(s) drank \_\_\_\_\_      Average # of drinks/week \_\_\_\_\_  
**Refined Sugars**      Usual type eaten \_\_\_\_\_      # of Servings per Week \_\_\_\_\_  
**Tobacco**      Average # packs/day \_\_\_\_\_      **Red Meat**      # of Servings per Week \_\_\_\_\_  
**Soft drinks**      Usual type drank \_\_\_\_\_      Average # of drinks/week \_\_\_\_\_  
Do you drink **bottled water**?       Yes     No      Do you buy **organic /natural foods**?  Yes  No  
**Dairy Products**      Usual type eaten \_\_\_\_\_      # of Servings per Week \_\_\_\_\_  
**Coffee**      Average # of cups/day \_\_\_\_\_      **Tea**      Average # of cups/day \_\_\_\_\_  
**Driving**      hrs/day \_\_\_\_\_      **Sitting**      hrs/day \_\_\_\_\_  
**FEMALES ONLY:** When was your last period? \_\_\_\_\_  
Do you suffer from PMS?      Yes    No  
Are you pregnant?      Yes    No      Maybe

*Doctor's Notes*

## YOUR CURRENT HEALTH IMPROVEMENT PLAN

Do you have an exercise program scheduled?

- Yes, presently it consists of \_\_\_\_\_
- I used to do \_\_\_\_\_
- I have never had one  I don't have one yet

What sports do you currently play? \_\_\_\_\_

Do you belong to a fitness club? Yes No Name of club \_\_\_\_\_

What is your favorite thing to do? \_\_\_\_\_

How happy are you?  Extremely  Moderately  Slightly  Not at All

How much balance do you think you have in your life?  Excellent  Moderate  Poor  Out of Control

How stressed in life do you feel you are?  Relaxed  Moderately Stressed  Extremely Stressed

How many days and hours per week do you work on average? \_\_\_ Days \_\_\_ Hours

Do you think this is  Too much  Not enough  Just right for you

Do you take vacations? Yes No If so, how much time off per year? \_\_\_\_\_

What are the 2 most important health goals for you?

1. \_\_\_\_\_

2. \_\_\_\_\_

Of the following, check the greatest two sources of stress in your life:

- |   |  |
|---|--|
| <input type="checkbox"/> Lack of money      | <input type="checkbox"/> Parenting                 |
| <input type="checkbox"/> Lack of time       | <input type="checkbox"/> Unhappy relationship(s)   |
| <input type="checkbox"/> Family and friends | <input type="checkbox"/> Poor health               |
| <input type="checkbox"/> Body image         | <input type="checkbox"/> Body signals (i.e., pain) |
| <input type="checkbox"/> Work/Career/School | <input type="checkbox"/> Other _____               |

How would you describe your body weight?

\_\_\_\_\_ 20 lbs or more overweight \_\_\_\_\_ 10 lbs overweight \_\_\_\_\_ ideal \_\_\_\_\_ need to gain weight

Are you currently trying to lose weight / diet? Yes No

Would you like professional help in losing weight? Yes No

Do you believe your weight and/or eating habits are contributing to your pain? Yes No

What would you like to accomplish?

\_\_\_\_\_ Identify the problem \_\_\_\_\_ Treatment Plan \_\_\_\_\_ Pain Reduction \_\_\_\_\_ Correct the problem

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date