

# HISTORY

When did your present complaints occur? \_\_\_\_\_

Who has treated you for this condition (if anyone) ? \_\_\_\_\_

Is this condition interfering with your  Work  Sleep  Recreation      Dates missed: \_\_\_\_\_

Have you had this condition or similar conditions in the past?  Yes  No    If so, when? \_\_\_\_\_

What treatment did you receive? \_\_\_\_\_

Name & location of previous Chiropractor? \_\_\_\_\_

Approximate date of last chiropractic treatment? \_\_\_\_\_

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto accidents: \_\_\_\_\_      Motorcycle accidents: \_\_\_\_\_

Falls or other injuries: \_\_\_\_\_      Spinal or neck injuries: \_\_\_\_\_

Broken bones: \_\_\_\_\_      knocked unconscious: \_\_\_\_\_

Surgeries: \_\_\_\_\_      Health problems of parents: \_\_\_\_\_

Who is your primary physician: \_\_\_\_\_      Phone: \_\_\_\_\_

When was your last complete checkup or exam? \_\_\_\_\_

List your current condition(s) in the order of decreasing severity:

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

Duration: \_\_\_\_\_      Frequency: \_\_\_\_\_

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

Duration: \_\_\_\_\_      Frequency: \_\_\_\_\_

3. \_\_\_\_\_

Duration: \_\_\_\_\_      Frequency: \_\_\_\_\_

4. \_\_\_\_\_

Duration: \_\_\_\_\_      Frequency: \_\_\_\_\_

5. \_\_\_\_\_

Duration: \_\_\_\_\_      Frequency: \_\_\_\_\_

## Status of Condition(s):

Using the following scale, please circle your response to each of the questions below. Zero (0) represents no pain/discomfort. **Ten (10)** represents the **most pain/discomfort** possible.

What is your least pain?	0	1	2	3	4	5	6	7	8	9	10
What is your worst pain?	0	1	2	3	4	5	6	7	8	9	10
What is your pain now?	0	1	2	3	4	5	6	7	8	9	10

Since the onset, indicate the course your condition(s) has taken

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Dramatically improved | <input type="checkbox"/> Somewhat improved     | <input type="checkbox"/> No change      |
| <input type="checkbox"/> Somewhat worsened     | <input type="checkbox"/> Dramatically worsened | <input type="checkbox"/> Not applicable |

**Please check any of the following that apply to your current/past medical history:**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Allergy<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Shoulder pain<br><input type="checkbox"/> Heartburn<br><input type="checkbox"/> Hay fever<br><input type="checkbox"/> Hiatal hernia<br><input type="checkbox"/> Migraines<br><input type="checkbox"/> Sore throats<br><input type="checkbox"/> Loss of weight<br><input type="checkbox"/> Shortness of breath<br><input type="checkbox"/> Hardening of arteries<br><input type="checkbox"/> Liver trouble<br><input type="checkbox"/> Hyperactivity<br><input type="checkbox"/> Numbness in legs or feet<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Swollen ankles<br><input type="checkbox"/> Stomach ulcers<br><input type="checkbox"/> Foot trouble<br><input type="checkbox"/> Frequent urination<br><input type="checkbox"/> Kidney stone<br><input type="checkbox"/> Kidney infection<br><input type="checkbox"/> Bladder infection<br><input type="checkbox"/> Painful urination<br><input type="checkbox"/> Poor urine control<br><input type="checkbox"/> Blood in urine<br><input type="checkbox"/> Prostate trouble<br><input type="checkbox"/> Swollen joints<br><input type="checkbox"/> Belching or gas<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Colon trouble<br><input type="checkbox"/> Headaches<br><input type="checkbox"/> Nosebleeds<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Jaundice<br><input type="checkbox"/> Polio<br><input type="checkbox"/> Bursitis<br><input type="checkbox"/> Poor circulation<br><input type="checkbox"/> Sprained ankle<br><input type="checkbox"/> Vomiting of blood<br><input type="checkbox"/> Bed-wetting<br><input type="checkbox"/> Low backache<br><input type="checkbox"/> Painful tailbone<br><input type="checkbox"/> Sciatica<br><input type="checkbox"/> Spinal curvature<br><input type="checkbox"/> Stiff or painful neck<br><input type="checkbox"/> Leg pain<br><input type="checkbox"/> Pain between shoulders<br><input type="checkbox"/> Arm Pain<br><input type="checkbox"/> Knee Pain<br><input type="checkbox"/> Thyroid trouble<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Enlarged Glands<br><input type="checkbox"/> Gout<br><input type="checkbox"/> Nasal congestion<br><input type="checkbox"/> Itching<br><input type="checkbox"/> Chronic cough<br><input type="checkbox"/> Heart disease<br><input type="checkbox"/> Hemorrhoids<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Chest pain<br><input type="checkbox"/> Vomiting<br><input type="checkbox"/> Broken bones<br><input type="checkbox"/> Weakness in legs<br><input type="checkbox"/> Rheumatic fever<br><input type="checkbox"/> Sinus infection<br><input type="checkbox"/> Convulsions | <input type="checkbox"/> Stomach aches<br><input type="checkbox"/> Dentures<br><input type="checkbox"/> Bruise easily<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Varicose veins<br><input type="checkbox"/> Gall bladder trouble<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Emphysema<br><input type="checkbox"/> Low blood pressure<br><input type="checkbox"/> Poor appetite<br><input type="checkbox"/> Surgery<br><input type="checkbox"/> Weakness in arms<br><input type="checkbox"/> Slow heart beat<br><input type="checkbox"/> Bad posture<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Poor hearing<br><input type="checkbox"/> Burning sensations | <input type="checkbox"/> Fatigue<br><input type="checkbox"/> Eczema/Hives<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Loss of sleep<br><input type="checkbox"/> Excessive hunger<br><input type="checkbox"/> Nervousness<br><input type="checkbox"/> Spitting up blood<br><input type="checkbox"/> High blood pressure<br><input type="checkbox"/> Nausea<br><input type="checkbox"/> Tumor<br><input type="checkbox"/> Numbness in arms/hands<br><input type="checkbox"/> Rapid heart beat<br><input type="checkbox"/> Difficulty swallowing<br><input type="checkbox"/> Heart attack<br><input type="checkbox"/> Ringing in ears<br><input type="checkbox"/> Angina |
|---|---|--|--|

### For Women Only:

- |   |   |
|---|---|
| <input type="checkbox"/> Premenstrual tension | <input type="checkbox"/> Unable to get pregnant |
| <input type="checkbox"/> Menopausal symptoms  | <input type="checkbox"/> Menstrual cramps       |
| <input type="checkbox"/> Excessive flow       | <input type="checkbox"/> Hysterectomy           |
| <input type="checkbox"/> Tubal ligation       | <input type="checkbox"/> Lumps in breast        |
| <input type="checkbox"/> Vaginal discharge    | <input type="checkbox"/> Irregular cycle        |

Is there a possibility that you may be pregnant?  YES  NO  
 Date of last menstrual period \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Carlsbad Village Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Carlsbad Village Chiropractic will be to my account on the receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_