

Personal History Form

Name: _____ Age: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work: _____ Cel: _____
E-mail: _____ S.S.#: _____
Health Insurance Co.: _____ Employer: _____
Occupation: _____ Referred by: _____
In case of emergency contact: _____ Tel: _____
Have you ever been treated by a chiropractor before? Yes No If Yes, when was the last time?

What is the reason for this visit?

How would you describe your chief complaint at this time?

When did it start? (include month and year, day if known):

How would you describe your pain?

- sharp dull throbbing numbness aching shooting burning tingling
 cramps stiffness Soreness swelling Other: _____

What makes the pain worse?

What makes the pain better?

Is this condition getting progressively worse?

At what time of the day or week is your pain worse?

What activities are difficult to perform?

- Sitting Standing Walking Bending Lying down Other: _____

Have you had this problem in the past? Yes No If yes, how often? _____

What treatment have you already received for your condition?

- Medication Surgery Physical Therapy Other: _____

Is your pain the result of a motor vehicle accident? Yes No

If yes, have you filed a claim? Yes No

Is your pain the result of a work related injury? Yes No

If yes, have you filed a worker's compensation claim? Yes No

Please list accidents, injuries, surgeries and hospitalizations you have had.

Do you or other direct family member (parents and siblings) have history of any of the following?

Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, who: _____
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, who: _____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, who: _____
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, who: _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, who: _____
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, who: _____
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, who: _____
Hypoglycemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, who: _____
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, who: _____
Mental Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, who: _____
Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, who: _____
Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, who: _____
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, who: _____

Do you drink coffee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how much per day?
Do you smoke tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how much per day?
Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If so, how often?

What activities do your daily work habits include?

Sitting Standing Light labor Heavy labor Driving Computer work Other: _____

What type of exercises do you perform on a daily basis?

None Moderate Heavy Type: _____

How many times do you engage in physical activity that is sufficient prolonged and intense to cause sweating and raise your heart rate?

Never 1-2/week 3-4/week 5-6/week everyday

When do you engage in the physical activity noted above, what is the average duration of activity?

> 10 min 10-20 min 20-30 min 30-60 min < 60 min

Please, rate your level of fitness (0 = very poor, 5 = average, 10 = excellent).

0 1 2 3 4 5 6 7 8 9 10

What medications, vitamins, supplements, herbs do you take?

Please, list any allergies that you have.

Patient Signature: _____ **Date:** _____