Health History

Name ______________________
Date ______________________

Describe the purpose of this visit ________________
____
____

When did this condition begin?__ days/weeks/months ago
Did it come on □suddenly □gradually
Has this condition: □gotten worse □gotten better
□stayed the same □comes and goes

Has this problem occurred in the past? □No □Yes
When did it first appear? ___ weeks/months/years ago
How often does problem reoccur? every ___ weeks/months/years

Is the purpose of this appointment related to
□Work Injury □Auto □Sports □Fall □Chronic Discomfort □Home injury □Other__________

Does this condition interfere with: □Work □Sleep
□ Daily Routine □ Exercise □ Household chores
□ Mood/Attitiude □ Other _______

When is pain worse? □a.m. □p.m. □during sleep
□during exercise □when standing up □with bending
□lying down □when walking □standing □sitting

Has your pain been associated with □excessive fatigue
□weight loss □low grade fever □bowel or bladder problems □kidney pain □night pain or night sweats
□abdominal pain □balance problems □ovarian pain

Have you seen other doctors for this condition?
□No □Yes Dr.(s) name ____________________
Type of Treatment ____________________
Results ____________________

Location Of Complaints

Chief Complaint/Region of Pain

____
____
____

Severity of Pain

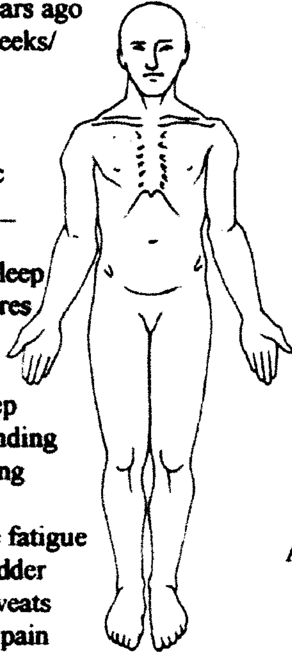
Mark area of pain on drawing and circle severity number below
(1= least 10 = greatest)

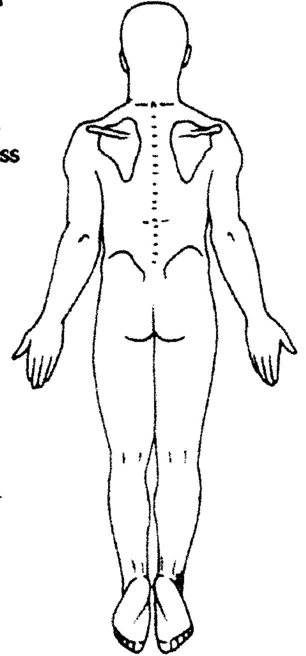
Mark Region of Pain

eg Neck ___Sharp___
1 2 3 4 5 6 7 (8) 9 10

Mark Pain Area

XXX Pain 000 Stiffness
+++ Burning - - - Numbness
Tingling





Regions

Neck ____________
1 2 3 4 5 6 7 8 9 10

Mid Back ____________
1 2 3 4 5 6 7 8 9 10

Low Back ____________
1 2 3 4 5 6 7 8 9 10

Hips ____________
1 2 3 4 5 6 7 8 9 10

Arms/Hands ____________
1 2 3 4 5 6 7 8 9 10

Legs/Feet ____________
1 2 3 4 5 6 7 8 9 10

Please mark area of pain on the drawing using the codes above

I have pain __ (%) of the time 0% 10% 25% 50% 75% 100%
(please circle)

Health Conditions

Please check each of these diseases or conditions that you have now or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and proper care plan.

□Headaches - Severe/Frequent
□Sinus Problems
□Dizziness
□Pain between the shoulders
□Neck Pain
□Lower Back Problems
□Digestive Problems
□Ulcers/Colitis
□Heart Attack/Stroke
□Numbness or Pain in Hands/Fingers/Legs
□Cold Feet/Hands
□ADD/ADHD

□Congential Heart Defect
□Heart Surgery/Pacemaker
□Heart Murmur
□High/Low Blood Pressure
□Difficulty Breathing
□Heal slowly
□Alcohol/Drug Addiction
□Addiction - Food/Work/Sex
□HIV/AIDS
□Diabetes
□Tuberculosis
□Low Blood Sugar
□Nervousness

□Shingles
□Kidney Problems
□Hepatitis
□Cancer
□Chemotherapy
□Anemia
□Arthritis
□Bruise easily
□Thyroid Problems
□Depression/Anxiety
□Sleeping Problems
□Incontinence
□Mood swings

□Chronic Fatigue
□Fibromyalgia
□Allergies/Asthma
□Frequent Colds/Flu
□Disorganized
□Seizures
□Eczema/Skin Rash
□Irregular cycles
□PMS
□Hot Flashes
□Painful Periods
□Are you pregnant?
□Are you nursing?

Injury History

Were you born in a hospital? No Yes
Did you fall as a child? No Yes
Did you play sports? No Yes
which sports ______________________________

Ever broken a bone? ☐No ☐Yes - which? ☐ vertebrae ☐collarbone ☐rib ☐arm/hand ☐pelvis/hip ☐foot/leg ☐skull ☐other______________________________

Prior Injury? ☐No ☐Yes - type? ☐Work Injury ☐Car Accident ☐Fall ☐Head Injury ☐Sports Injury ☐Lifitng Injury ☐Pedestrian ☐Military ☐Other ______________

Surgeries? ☐No ☐Yes - type? ☐Spine (neck, back or pelvis) ☐Disc surgey ☐Shoulder/Arm/Hand ☐Hip/Leg/Knee/Foot ☐Heart ☐Tonsils ☐Appendix ☐Gall Bladder/stomach ☐Hernia ☐C-section ☐Other______

Medications/Drugs

☐ None

☐Aspirin/Tylenol/Ibuprofren	☐Ritalin /Stimulants
☐Pain Killers	☐Heartburn/Acid reflex
☐Muscle Relaxers	☐Antidepressants
☐Blood Pressure Meds	☐Birth control pills
☐Allergy/Sinus pills	☐ Hormone Therapy
☐Insulin	other______________

Health Habits

Do you exercise regularly?☐No ☐1-2 week ☐3-5 week
Type? ☐stretching ☐ weights ☐ cardiovascular
Place? ☐home ☐gym/club ☐personal trainer

How much water do you drink? __________liters/day
Type of vitamin supplements ____________________

Do you drink coffee? No Yes ___cups/day
Do you drink soda pop? No Yes ___cans/day
Do you drink alcohol? No Yes ___drinks/day/week
Do you smoke? No Yes ___ packs/day

Do you wear: ☐Heel lifts ☐Orthotics ☐Arch Supports

Sleep quality ______________ # of hours ________

Health Concepts

Are you aware that:
The nervous system controls all body functions? Yes No
Chiropractors work with the nervous system? Yes No
Chiropractic is the largest natural healing profession in the world? Yes No
If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes No

Goals for My Care

People see Chiropractic care for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for corrections of whatever is malfunctioning in their bodies. Your needs and desires will be weighed by us along with your tests results when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Relief Care:** Symptomatic relief of pain or discomfort.
☐ **Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms
☐ **Comprehensive Wellness Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care.
☐ I want the Doctor to select the type of care appropriate for my condition.

Authorization for Examination

I herby authorize the practitioners at Stadelman Chiropractic Health Center and whomever they may designate as their assistants to perform an examination of me. I certify that the above information is true and correct.

______________________________ __________ ______________________________ __________
Patient's Signature Date Guardian or Spouse's Signature Authorizing Care Date