Patient Health History

Is the reason for your visit due to an accident? Yes / No ***If Yes, What type: Work / Auto / Personal Injury***

Name:_____ **Date:**_____

Preferred Phone:_____ **Email:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Sex: Male / Female **Birth Date:**_____ **Height:**_____ **Weight:**_____

Are You? Married / Single / Widowed Number of Children?_____

Business/Employer:_____ **Type of Work:**_____

Who referred you to our office?_____

1. Describe your symptoms:_____

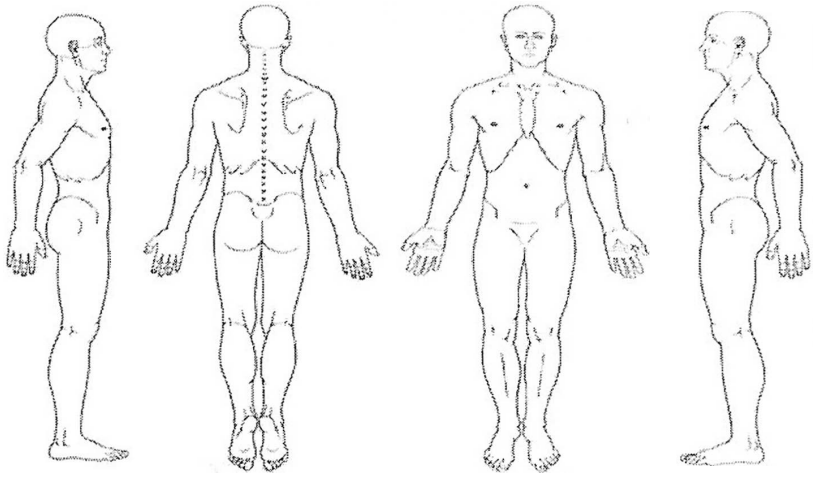
When and how did they begin:_____

_____

2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How *are* your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. How bad are your symptoms at their:

None *Unbearable*

a. worst: ⓪ ① ② ③ ④ ⑥ ⑥ ⑦ ⑧ ⑨ ⑩

b. best: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities*?*

⓪	①	②	③	④	⑤	⑥	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*	*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities *make* your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you *seen* for your symptoms?

- ☐ No One
- ☐ Other Chiropractor
- ☐ Medical Doctor
- ☐ Physical Therapist
- ☐ Other

What tests have you had for your symptoms and when were they performed?

- ☐ Xrays date:_____ ☐ CT Scan dates:_____
- ☐ MRI date:_____ ☐ Other dates:_____

10. Have you had similar symptoms in the past?

- ☐ Yes ☐ No

a. If you have received treatment in the past for the same or similar symptorris, who did you see?

- ☐ This Office
- ☐ Other Chiropractor
- ☐ Medical Doctor
- ☐ Physical Therapist
- ☐ Other

Patient Name _____

11. **What do you hope to get from your visit/treatment** (select all that apply):

☐ Reduce symptoms ☐ Explanation of condition/treatment ☐ How to prevent this from occurring again

☐ Resume/increase activity ☐ Learn how to take care of this on my own

What type *of* regular exercise *do you* perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

For each *of* the conditions listed below, place a check in the Past column if *you* have had the condition in the past. If *you* presently have a condition listed below, place a check in the Present column.

Past	*Present*	
☐	☐	Headaches
☐	☐	Neck Pain
	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Knee/Lower Leg Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Muscular Incoordination
☐	☐	Visual Disturbances
☐	☐	Dizziness

Past	*Present*	
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinusitis

Past	*Present*	
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Use Tobacco Products
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS

Females Only

☐ ☐ Birth Control Pills
☐ ☐ Hormonal Replacement
☐ ☐ Pregnancy
☐ ☐

Other Health Problems/Issues

☐ ☐
☐ ☐
☐ ☐

_____

***I*ndicate if an immediate family member has had any *of* the following:**

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus _____

List all prescription and over-the-counter medications, and nutritional / herbal supplements *you* are taking:

_____

_____

List all the surgical procedures *you* have had and times *you* have been hospitalized:

_____

_____

I have read the above information & certify it to be true &correct to the best of my knowledge, and hereby authorize Performance Health, P.C. to provide me with chiropractic care, in accordance with this state's statutes. If my insure will be billed, I authorize payment of medical benefits to Performance Health, P.C. for services performed.

Signature_____ **Date:**_____