SKAMANIA CHIROPRACTIC & Rehabilitation

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Health History

Birthdate:_____
(mm/dd/yyyy)

Patient Name:_____
(first name, middle initial, last name)

Date:_____
(mm/dd/yyyy)

Height: _____ **Weight:** _____ **Dominant Hand:** ● Left ● Right ● Both

Have you seen a chiropractor before? *If yes, explain?*
_____

Who is your Primary Care Physician? _____ Phone: _____

Other Physicians/Therapists: *List current ones:* _____

Traumas/Accidents: *List any and years:* _____

Hospitalizations/Surgeries: *List any and years:* _____

Medications/Supplements/Vitamins: *List any current prescriptions or over-the-counter ones you are taking.*

Name	Dosage	Frequency	Reason for Taking	Name	Dosage	Frequency	Reason for Taking
_____	____	____	_____	_____	____	____	_____
_____	____	____	_____	_____	____	____	_____
_____	____	____	_____	_____	____	____	_____

Have you had any courses of antibiotics recently? ● Yes ● No Cortisone recently? ● Yes ● No

Allergies: *List allergies to medication, food, pollens, chemicals…:* _____

Habits: *Please answer if you are using any of the following:*

Tobacco _____ per _____ ● Current ● Never ● Former (Quit in _____)

Alcohol _____ per _____
Marijuana ___ per _____

Tea _____per _____
Coffee _____ per_____

Energy Drink _____ per_____
Water (glass) _____ per ____

Exercise*: If yes, what kind?* _____

Family Medical History: *List diseases that apply. (ie., arthritis, heart disease, cancer, diabetes…). Note if deceased.*

Mother: _____ Father: _____
Sister(s): _____ Brother(s): _____
Grandmother(s): _____ Grandfather(s): _____

Past Medical History: *Circle and fill in <u>all</u> that apply.*

Mental Illness	Asthma	Gall Stones	Rheumatic Fever
Diabetes	Allergies	Venereal Disease	Thyroid Problems
Hepatitis	Stroke	Osteoporosis	Kidney Stones
HIV Positive AIDS	Arthritis	Seizures	Ulcers
High Blood Pressure	Herpes	Parasites	Cancer
Heart Disease	Chronic Fatigue	Mononucleosis	Other _____

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Review of Systems: *Circle and fill in all that apply.*

Musculoskeletal
An Issue/Problem with…
-Head
-Neck
-Upper/Mid Back
-Low Back
-Ribs
-Chest/Abdomen
-Shoulder/Arm
-Elbow/Forearm
-Wrist/Hand
-Buttock/Hip/Thigh
-Knee/Lower Leg
-Ankle/Foot
-Joint/Bone/Muscle

Head/ENT
Headaches
Migraines
Dizziness
Jaw Pain
Facial Pain
Grinding teeth
Recurrent sore throat
Poor hearing
Facial Pain
Grinding teeth
Recurrent sore throat
Poor hearing
Swollen glands
Ringing in ears
Tonsillitis
Blurry vision

Neurological
Poor Balance
Tremors
Seizures
Concussion
Nerve damage
Paralysis
Vertigo
Trouble concentrating
Lack of coordination
Poor memory

Endocrine
Thyroid problems
Hair loss
Blood sugar issues
Adrenal problems
Stress/tension
Light headed
Wake up tired
Fatigue/Tired
Loss of energy
Energy drops
Poor sleep
Crave sweets
Strong thirst
Night sweats
Sweat easily

Behavioral
Panic attacks
Anxiety
Depression
Substance abuse

Skin
Rashes
Itching
Eczema
Recent moles
Change in hair/skin

Respiratory
Difficulty breathing
Pain with breathing
Shallow breathing
Shortness of breath
Bronchitis
Production of phlegm
Pneumonia
Asthma/wheezing
Recurrent cough

Cardiovascular
Pacemaker
High blood pressure
Low blood pressure
Chest discomfort/pain
Heart Palpations
Cold hands or feet
Swelling of hands or feet
Edema
Blood clots
Fainting

Digestion
Bad breath
Change in appetite
Loose stools/diarrhea
Heartburn
Indigestion
Belching
Nausea
Vomiting
Abdominal pain/cramps
Constipation
Rectal pain
Hemorrhoids
Pain with passing stools
Bulimia
Anorexia nervosa

Genital-urinary
Hemorrhoids
Pain with passing stools
Bulimia
Anorexia nervosa

Genital-urinary
Pain on urination
Urgency with urination
Frequent urination
Blood in urine
Prostate problems
Decrease in urinary
Unable to hold urine
Kidney stones

Gynecological
# of pregnancies_____
# of births_____
premature births___
Age of 1st menses____
Age of menopause___
Date of last PAP_____
PMS
Irregular periods
Painful periods
Light periods
Heavy periods
Fibroids
Endometriosis
Infertility
Practice birth control
Pregnant Yes No
Due Date_____

SKAMANIA
CHIROPRACTIC
& Rehabilitation

Complaints / Concerns

Birthdate:_____
(mm/dd/yyyy)

Patient Name:_____
(first name, middle initial)

Date:_____
(mm/dd/yyyy)

Complaints/Reasons for contacting us: *Circle and fill in all that apply*

Complaint(s)?	**Severity:** *How bad is it on a 0-10 scale?* 0=No problem 10= Worst possible problem	**Frequency/Duration:** *What percent of the time does the complaint bother you?*
Neck	0 1 2 3 4 5 6 7 8 9 10	0-25 26-50 51-75 76-100
Upper / Mid Back	0 1 2 3 4 5 6 7 8 9 10	0-25 26-50 51-75 76-100
Low Back	0 1 2 3 4 5 6 7 8 9 10	0-25 26-50 51-75 76-100
_____	0 1 2 3 4 5 6 7 8 9 10	0-25 26-50 51-75 76-100
_____	0 1 2 3 4 5 6 7 8 9 10	0-25 26-50 51-75 76-100

Quality of Symptoms: *What does it feel like?* Pain Numb Tingling Stiff Sore Dull Ache Cramp Nagging Sharp Burning Shooting Throbbing Stabbing

Onset: *When did your complaint(s) begin?* _____

Did your complaint(s) begin…? Suddenly Gradually Unknown

What caused your complaint(s)? Auto Collision Work Injury Sports Injury Other Unknown

Progress: *Is your condition getting…?* Better Same Worse

Timing: *When is it worse?* Morning Afternoon Evening Nighttime Always the same

Radiation: *To what areas does it shoot or travel?* _____

Palliating: *What makes your complaint(s) better?* Nothing Lying Sitting Walking Standing Stretching Exercise Heat Ice Other _____

Provoking: *What makes your complaint(s) worse?* Nothing Bending Lifting Sitting Walking Standing Reaching Coughing Sneezing Other _____

ADL's (Activities of Daily Living): *Where does it interfere with your life?* Work School Caring for Children Exercise Recreation Activities Sleep Household Chores Self Care Personal Relationships Social Life Other_____

Other Health Providers seen for the above complaint(s): _____

_____

Please indicate any areas causing pain or distress: