Reset Form | Submit Form | Print Form

Patient (Practice Member) History

Last Name	First Name	M.I.	Date
Address	City	State Maryland	Zip
H. Phone	W. Phone	C. Phone	
Date of Birth	Age	Email	
	Occupation	Employer	
Referred by	Marital Status S M D W	Spouse Name	
Have you ever received Chiropractic Care? Yes No When		Frequency Please Choose...	

Please check for each of the following:

1. Regarding YOUR Birth Process:	Yes	No	Comment		Yes	No	Comment
Was the delivery long/difficult?				Home birth?			
Forceps or extraction used?				Hospital birth?			
Cesarean/ C-Section?				Mother given drugs at delivery?			
Breach/ cephalic?				Was labor induced?			

2. Growth and Development/ Childhood:							
Were you breast fed?				Surgery?			
Health education?				Hospitalizations?			
Childhood illnesses?				Sports or other physical activities			
Ear infections/ Colic/ Asthma?				Injuries during sports?			
Attention Deficit?				Auto accidents?			
Antibiotics?				Did you have other traumas?			
Drugs, prescription, OTC, recreational?				Did you ever break any bones?			

3. Current Health Habits:							
Did/do you smoke?				Hearing problems?			
Did/do you drink alcohol?				Exercise regularly?			
Diet, do you eat healthy foods?				Did/do you have job stress?			
Have you been in accidents/trauma?				Drive? Daily time spent driving			
Have you had surgery?				Physical stress?			
Meds prescription, OTC, recreational?				Emotional/Mental stress?			
Dental problems?				Hobbies/Sports injuries?			
Eye problems?				Do you sleep well, hours of sleep?			
Sleeping posture?							

Symptoms and Present State of Health

Present Complaint/Reason for seeking care in this office:
Pain or Problem started on
Pains are: Sharp Dull/ Ache Constant Intermittent Other
Does this pain shoot, radiate, or travel in your body? Please Choose... Where?
Are you experiencing numbness or tingling in any area of your body? Please Choose... Where?
Since it began, is it: Same Better Worse
What activities aggravate your condition/pain?
What activities lessen your condition/pain?
Is this condition worse during certain times of the day?
Is this condition interfering with Work? Sleep? Routine? Other?
Is this condition progressively getting worse?
Other Doctors seen for this condition
Any home remedies?
Please rate any pain from 0 to 10 with 0 = none, and 10 = worse possible. What number are you? Please Choose ...

Please mark any of the following conditions or symptoms that you have now or have experienced:

☐	Headaches	☐	Pain in Hands or Arms	☐	Chest Pains
☐	Neck Pain	☐	Numbness in Hands or Arms	☐	Heart Attack
☐	Sleeping Problems	☐	Pain in Legs or Feet	☐	High Blood Pressure
☐	Low Back Pain	☐	Numbness in Legs or Feet	☐	Stroke
☐	Nervousness	☐	Fatigue	☐	Cancer
☐	Tension	☐	Depression	☐	Menopause
☐	Irritability	☐	Cold Feet	☐	Diabetes
☐	Dizziness	☐	Loss of Memory	☐	Diarrhea
☐	Pain Between Shoulders	☐	Shoulder Pain	☐	Constipation
☐	Neck Stiff	☐	Sinus	☐	Stomach Upset
☐	Joint Swelling	☐	Shortness of Breath	☐	Heartburn/Reflux
☐	Fever	☐	Asthma	☐	Weight Loss
☐	Loss of Balance	☐	Allergies	☐	Loss of Smell or Taste
☐	Ringing in Ears	☐	Cold Hands	☐	Menstrual Cramps
☐	Jaw/TMJ Problems	☐	Lights Bother Eyes	☐	Painful Urination
☐					

Other Symptoms:

Are you under medical care for any condition? Yes ◯ No ◯	
List medications/reasons and duration:	
List surgery and dates:	
List hospitalization/date/reason:	
List broken bones/cause/date	
Females Only – Date last menstrual period began on:	Are you possibly pregnant?

Is there a family history of:

Arthritis	Neither	Cancer	Neither	Diabetes	Neither	Heart Disease	Neither	Other	

Any other information that you would like to offer:

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient (Practice Member) Signature_____Date_____