

CONFIDENTIAL HEALTH HISTORY

Patient Information

*Thank you for choosing our practice for your chiropractic needs.
If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.*

Date: _____ E-mail Address: _____
Name (First): _____ MI: _____ (Last): _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: Home: _____ Work: _____ Cell: _____
Birthdate: _____ Age: _____ Height: _____ Weight: _____ Social Security #: _____
Are you? Male Female Married Single Widowed Divorced Separated
Do you have children? Yes No Ages: _____
Your Employer: _____ Occupation: _____
Business Address: _____ City: _____ State: _____ Zip: _____
Spouse's or Parent's Name: _____ Workplace: _____ Work Phone: _____
Whom may we notify in an emergency? Name: _____ Phone: _____ Relationship: _____

Symptoms

Reason for visit: _____
When did your problem begin? _____
Did it begin: Gradual Sudden Progression over time
Have you experienced a similar problem before? _____
Did it start from an injury? Yes No What happened? _____
Is this condition getting: Better Worse Staying the same
Which activities are difficult to perform? Sitting Standing Walking Bending Lying Down
 Other: _____
Type of Pain: Sharp Numbness Aching Shooting Tingling Cramps
 Dull Stiffness Throbbing Burning
Rate the severity of your pain (1-mild pain or discomfort to 10-severe pain):
1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? _____
What makes it better? _____
What makes it worse? _____
What treatment have you already received for your condition? _____
 Medication Surgery Physical Therapy Other _____

Name and address of other practitioner(s) who have treated you for your condition:

Health History

Check conditions that apply:

- | | | | |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Fracture/Broken Bone | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Problems. |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hernia | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Polio | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychiatric Care | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Sinus | _____ |

Date of last medical exam? _____

(Women) Are you pregnant? Yes No Nursing? Yes No
Taking birth control pills? Yes No

List any surgeries you have had and any times you have been hospitalized (include dates):

Please list all medications that you are currently taking and the reasons:

Have you ever been seen by a chiropractor before? Yes No When? _____
For what condition? _____

Family History

Does anyone in your family have a condition similar to yours? Yes No Who? _____
Does anyone in your family have?
 Arthritis Back Pain Cancer Diabetes Disc Disorders
 Headaches Heart Disease High Blood Pressure Migraine Headaches

Daily Habits

What type of exercise do you perform on a daily basis? None Moderate Heavy
What do your daily work habits include (i.e. standing, sitting, light labor, heavy labor, computer work):

What vitamins do you currently take? _____
What kind of other nutritional supplements do you take (if any)? _____
Do you smoke? Yes No
How much alcohol do you consume on a weekly basis? _____
How much coffee or caffeinated beverages do you consume on a daily basis? _____

Authorization

I certify that I have read and understand and answered the above information to the best of my knowledge. I authorize Dr. Lohr to perform a chiropractic evaluation and, if appropriate, treatments for my condition.

X _____
Signature of Patient (or parent if a minor) Date