Arlington Chiropractic Center
Confidential Patient Health Information

Personal History **Patient Account # _____**

Name: _____ Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Birth Date: _____/_____/_____ Age: _____ M / F Social Security # _____/____/_____

Marital Status: Single / Married / Widowed / Divorced / Separated # of Children: _____

Home # (____) _____ Work # (____) _____ Cell # (____) _____

Cell Provider: ATT, Verizon, Sprint, T-Mobile, Other:_____ Can we text you Appt. Info? Yes / No

Patient's Email: _____Guardian: _____

Employer:_____ Type of Work: _____

Name of Spouse: _____ Spouse's Date of Birth:_____

Spouse's Employer:_____ Phone: (____) _____ SS: ____/____/_____

Who is responsible for the bill: Self Spouse Worker's Comp Auto Ins. Medicare/Medicaid

How did you hear about our office: _____

Current Health History

Purpose of the appointment: _____

When did the condition or injury most recently bother you: _____/_____/_____

How frequent is your pain: _____ Does the pain go into your Arms Legs

What makes it better: _____ What makes it worse: _____

What types of treatment have you tried: _____

What were the results: _____

Has this condition occurred before: No Yes, When & How Often:_____

Did this condition happen while at: Home Auto Accident Fall Work Unknown

Other: _____

Do you suffer from any condition other than what you are here for today: _____

_____

Past Health History

List any major surgeries/operations and year performed: _____

_____

Accidents/ Falls: _____

Have you had any previous Chiropractic Care: _____

Check any of the following diseases you have had: Name Date Account #

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarette
- ☐ Sugar

Check any of the following you have had in the last year (Y) or Longer (L)

Musculo_Skeletal

- ☐ Y ☐ L Low Back Pain
- ☐ Y ☐ L Pain Between Shoulders
- ☐ Y ☐ L Neck Pain
- ☐ Y ☐ L Arm Pain
- ☐ Y ☐ L Joint Pain / Stiffness
- ☐ Y ☐ L Walking Problems
- ☐ Y ☐ L Difficult Chewing
- ☐ Y ☐ L Clicking Jaw
- ☐ Y ☐ L General Stiffness

Nervous System

- ☐ Y ☐ L Nervous
- ☐ Y ☐ L Numbness
- ☐ Y ☐ L Paralysis
- ☐ Y ☐ L Dizziness
- ☐ Y ☐ L Forgetfulness
- ☐ Y ☐ L Confusion / Depression
- ☐ Y ☐ L Fainting
- ☐ Y ☐ L Convulsions
- ☐ Y ☐ L Cold/ Tingling Extremities
- ☐ Y ☐ L Stress

General

- ☐ Y ☐ L Fatigue
- ☐ Y ☐ L Allergies
- ☐ Y ☐ L Loss of Sleep
- ☐ Y ☐ L Fever
- ☐ Y ☐ L Headaches

Eye, Ears, Nose, Throat

- ☐ Y ☐ L Vision Problems
- ☐ Y ☐ L Dental Problems
- ☐ Y ☐ L Sore Throat
- ☐ Y ☐ L Ear Aches
- ☐ Y ☐ L Hearing Difficulty
- ☐ Y ☐ L Stuffed Nose
- ☐ Y ☐ L Pregnant? When was your last period?_____

Gastro-Intestinal

- ☐ Y ☐ L Poor/Excessive Appetite
- ☐ Y ☐ L Excessive Thirst
- ☐ Y ☐ L Frequent Nausea
- ☐ Y ☐ L Diarrhea
- ☐ Y ☐ L Constipation
- ☐ Y ☐ L Liver Problems
- ☐ Y ☐ L Gall Bladder Problems
- ☐ Y ☐ L Weight Problems
- ☐ Y ☐ L Abdominal Problems
- ☐ Y ☐ L Gas/Bloating
- ☐ Y ☐ L Heart Burn
- ☐ Y ☐ L Black / Bloody Stools
- ☐ Y ☐ L Colitis

Genito-Urinary

- ☐ Y ☐ L Bladder Problems
- ☐ Y ☐ L Painful Urination
- ☐ Y ☐ L Excessive Urination
- ☐ Y ☐ L Discolored Urination

Cardio-Vascular- Respirtory

- ☐ Y ☐ L Chest Pain
- ☐ Y ☐ L Short Breath
- ☐ Y ☐ L Blood Pressure Problems
- ☐ Y ☐ L Irregular Heart Beat
- ☐ Y ☐ L Heart Problems
- ☐ Y ☐ L Lung Problems
- ☐ Y ☐ L Lung Congestion
- ☐ Y ☐ L Varicose Veins
- ☐ Y ☐ L Ankle Swelling
- ☐ Y ☐ L Stroke

Male - Female

- ☐ Y ☐ L Menstral Irregularity
- ☐ Y ☐ L Menstral Cramps
- ☐ Y ☐ L Vaginal Pain / Infection
- ☐ Y ☐ L Breast Pain / Lumps
- ☐ Y ☐ L Prostate
- ☐ Y ☐ L Sexual Dysfunction

Family History

The following members have a same or similar problem or problems as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child
- ☐ Grandma
- ☐ Grandpa

Date Account #

Past Health History

Do you have any of the following? Please check **Yes** or **No** for each condition.

Relative Contraindications:			**Absolute Contraindications:**		
Articular Hypermobility Disease	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No
Severe Demineralization of Bone	☐Yes	☐No	Anklosing Spondylitis	☐Yes	☐No
Benign Bone Tumor (Spine)	☐Yes	☐No	Fracture(s) _____	☐Yes	☐No
Bleeding Disorder	☐Yes	☐No	Dislocation(s) _____	☐Yes	☐No
Are You Taking Anti Coagulant Therapy	☐Yes	☐No	Unstable OS Odontoedeum	☐Yes	☐No
Radiculopathy with Progressive			Malignancies that involve the vertebral column	☐Yes	☐No
Neurological Signs:	☐Yes	☐No	Infection of bones of the vertebral column	☐Yes	☐No
Radiating Pain, Numbness, or Weakness in			Myelopathy	☐Yes	☐No
Upper Extremities	☐Yes	☐No	Cauda Equina Syndrome	☐Yes	☐No
Lower Extremities	☐Yes	☐No	Vertebrobasilar Insufficiency Syndrome	☐Yes	☐No

Previous Major Illnesses/Injuries: _____

Hospitalizations (with year): _____

Medications you are currently taking:

☐High Blood Pressure: _____ ☐Cholesterol: _____ ☐Pain: _____ ☐Arthritis: _____

☐Depression: _____ ☐Anxiety: _____ ☐ADD/ADHD: _____ ☐Insulin: _____

☐Other: _____

☐List known Allergies:_____

Family History – Immediate Family (Father, Mother, Siblings and, Children)

Health Status of Family Members: _____

Are there any family members that suffer from:

☐Stroke ☐Heart Attack ☐Cancer ☐Tumor ☐Degenerative Disk Disease ☐Arthritis ☐Osteoporosis

☐Other: _____

If any of the above items are checked, then, whom in your family? _____

Are there any other diseases that are "hereditary" or seem to "run in your family"? _____

Social History – Please answer the following :

Please tell the Doctor about your activities:

Exercise:	Work/ School	Habits: □None	Education:
☐None	☐Sitting	☐Smoking –Packs per Day_____	☐High School
☐Occasional	☐Standing	☐Alcohol – Times Per Week _____	☐Some College
☐Daily	☐Light Labor	☐Caffeine; Coffee, Sodas, Tea… Cups Per Day _____	☐College Grad
☐Weekly	☐Heavy Labor	☐Hobbies _____	☐Post Grad
☐Other	☐Computer	☐Drugs _____	

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with State statues.

Patient Signature: _____ Date: _____/_____/_____

I have reviewed this form: _____ Date: _____/_____/_____

Doctor's Signature

Symptom(s) Questionnaire

Patient Name _____ Account # _____ ☐ Initial Visit ☐ Subsequent Visit

Please tell us about your symptoms: _____

_____

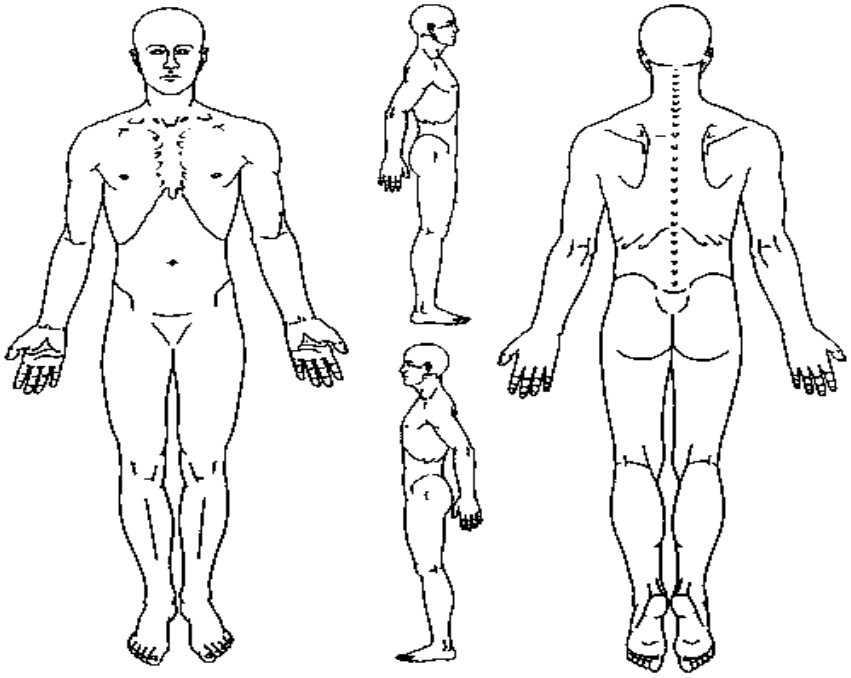
My pain / symptom(s) are getting: Better Worse About the same Other

Please use the key to mark the diagram

Pain / Discomfort Scale: (please Circle) Least 0 1 2 3 4 5 6 7 8 9 10+ Worst

A = Ache B = Burning N = Numbness S = Stiff SR = Sore

T = Tingle P = Pain W = Weak P&N = Pins & Needles



lease tell us how your symptoms are affecting your activities

HOME	No Affect	Mild Affect	Moderate Affect	Severe Affect
Sleeping	☐	☐	☐	☐
Self Care	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐
Productivity	☐	☐	☐	☐

WORK	No Affect	Mild Affect	Moderate Affect	Severe Affect
Concentration	☐	☐	☐	☐
Duties, Activities	☐	☐	☐	☐
Mood	☐	☐	☐	☐
Travel	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐
Productivity	☐	☐	☐	☐

OTHER ACTIVITIES	No Affect	Mild Affect	Moderate Affect	Severe Affect
Sit, Stand, Walk	☐	☐	☐	☐
Raising from Chair	☐	☐	☐	☐
Bend, Lift, Twist	☐	☐	☐	☐
Turn Head	☐	☐	☐	☐
Hobbies, Exercise, Sports	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐

Patient Signature _____ Date ____/____/____

Doctor Signature Date ____/____/____

Neurological And Vascular Patient Questionnarie

Name:_____ Number:_____ Date:_____

1) Do you suffer from neck pain with pain in your shoulders, arms, or hands? Yes / No
Comments:_____

2) Do you have weakness, numbness, or burning in your shoulder, arms or hands? Yes / No
Comments:_____

3) Do you hands or arms fall asleep regularly? Yes / No
Comments:_____

4) Do you have reduced feeling (sensation) or swelling in your hands or arms? Yes / No
Comments:_____

5) Do you suffer from a loss of handgrip or strength? Yes / No
Comments:_____

6) Do you suffer from back pain with pain in your buttocks, legs or feet? Yes / No
Comments:_____

7) Do you have weakness, numbness or burning in your buttocks, legs, or feet? Yes / No
Comments:_____

8) Do you legs or feet fall asleep regularly? Yes / No
Comments:_____

9) Do you have reduced feeling (sensation) or swelling in your legs, feet? Yes / No
Comments:_____

10) Do you suffer from cold hands or feet? Yes / No
Comments:_____

11) Do you suffer from headaches, dizziness, or memory loss? Yes / No
Comments:_____

12) Do you have difficulty maintaining your balance? Yes / No
Comments:_____

13) Do you suffer from vertigo or blurred vision? Yes / No
Comments:_____

14) Do you suffer from a reduced hearing capacity? Yes / No
Comments:_____

15) Do you suffer from ringing in your ears? Yes / No
Comments:_____

16) Do you have bladder or bowel control problems on a regular basis? Yes / No
Comments:_____