Personal History

Name: _____ Date: _____

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

Home No: _____ Work No.: _____ Cell No.: _____ DOB: _____Age: _____

E-Mail: _____ Referred by: _____

Occupation: _____ Employer: _____

Marital Status: S M D W Spouse Name: _____

Number of Children/ Ages: _____ Spouses Occupation: _____

Name Address and Phone Number of primary care physician: _____

Have you ever received chiropractic care? No Yes Name and location of Doctor: _____

Chief Complaint

What is your primary complaint/reason for seeking care in this office?

_____

Problem started on: _____

How would you describe your pain? Sore Achy Sharp Shooting Dull Burning Throbbing Spasm Numbing Tingling Stabbing Tight

How often are you experiencing your pain? ¼ of day ¼ to ½ of day ½ to ¾ of day Constant

Does this pain shoot, radiate or travel in your body? Where? _____

Are you experiencing numbness or tingling in any area of your body? Where? _____

What makes the pain worse? _____

What makes the pain better? _____

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? _____

Please circle where you are: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Other doctors seen for this condition: _____

How long have you had pain before your sought treatment? _____

How many times have you had the problem in the past? _____

Do you exercise? If so how often and what type? _____

Current Health Habits: *(Patient Comment If Answer is Yes)*

Did/do you smoke? If so how many packs/day?	Yes	No	_____
Did/do you drink alcohol? How many drinks/wk?	Yes	No	_____
Dental problems?	Yes	No	_____
Do you sleep well? Sleeping Posture?	Yes	No	❍side ❍stomach ❍back
Did/do you have occupational stress?	Yes	No	_____
Physical Stress?	Yes	No	_____
Emotional/Mental stress?	Yes	No	_____
Hobbies/Sports?	Yes	No	_____

For each of the conditions listed below, please 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		Past	Present		Past	Present	
❍	❍	Headaches	❍	❍	High Blood Pressure	❍	❍	Diabetes
❍	❍	Neck Pain	❍	❍	Heart Attack	❍	❍	Excessive Thirst
❍	❍	Upper Back Pain	❍	❍	Chest Pains	❍	❍	Frequent Urination
❍	❍	Mid Back Pain	❍	❍	Stroke			
❍	❍	Low Back Pain	❍	❍	Angina	❍	❍	Smoking/Tobacco Use
						❍	❍	Drug/Alcohol Dep.
❍	❍	Shoulder Pain	❍	❍	Kidney Stones			
❍	❍	Elbow/Upper Arm Pain	❍	❍	Kidney Disorders	❍	❍	Allergies
❍	❍	Wrist Pain	❍	❍	Bladder Infections	❍	❍	Depression
❍	❍	Hand Pain	❍	❍	Painful Urination	❍	❍	Systemic Lupus
			❍	❍	Loss of Bladder Control	❍	❍	Epilepsy
❍	❍	Hip/Upper Leg Pain	❍	❍	Prostate Problems	❍	❍	Dermatitis/Eczema
❍	❍	Knee/Lower Leg Pain				❍	❍	HIV/AIDS
❍	❍	Ankle/Foot Pain	❍	❍	Abnormal Weight Gain/Loss			
			❍	❍	Loss of Appetite	**Females Only**		
❍	❍	Jaw Pain	❍	❍	Abdominal Pain	❍	❍	Pregnancy
			❍	❍	Ulcer	❍	❍	Birth Control Pills
❍	❍	Joint Swelling/Stiffness	❍	❍	Hepatitis	❍	❍	Hormone Replacement
❍	❍	Arthritis	❍	❍	Liver/Gall Bladder Disorder			
❍	❍	Rheumatoid Arthritis	❍	❍	Thyroid Disorder	**Other Health Problems/Issues**		
			❍	❍	Cancer	❍	❍	_____
❍	❍	General Fatigue	❍	❍	Tumor	❍	❍	_____
❍	❍	Muscular Incoordination						
❍	❍	Visual Disturbances	❍	❍	Asthma	**List Surgeries/Dates Hospitalized**		
❍	❍	Dizziness	❍	❍	Chronic Sinusitis	_____		
❍	❍	Loss of Balance				_____		
❍	❍	Nervousness	❍	❍	Diarrhea	_____		
❍	❍	Fever	❍	❍	Constipation	_____		
❍	❍	Loss of Memory	❍	❍	Upset Stomach	_____		
❍	❍	Loss of Smell/Taste						
❍	❍	Loss of Hearing/Ringing in ears						

List all prescription/over the counter medications and nutritional supplements you are taking _____

Females Only- Date last menstrual period began _____ Pregnant? _____

Is there a family history of?

	Heart Disease	Arthritis	Cancer	Diabetes
Father's Side	❍	❍	❍	❍
Mother's Side	❍	❍	❍	❍

Insurance Information

Do you have health insurance? ❍Yes ❍No Name of Company: _____

Do you have secondary insurance? ❍Yes ❍No Name of Company: _____

Policy #: _____ Group #: _____ Employer: _____

Insured's Name: _____ Date of Birth: _____

Payment Acknowledgement:

I request that payment of authorized benefits be made to Clearwater Sports & Wellness for any services furnished to me. I authorize any holder of medical information about me to be released to the health care financing administration, it's agents, and my insurance company needed to determine these benefits or the benefits payable for related services. I also understand that this office will prepare any forms and reports necessary to assist in making collection from the insurance company. **However, I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment.**

Patient Signature: _____ Date: _____