

INITIAL HEALTH HISTORY

Patient Name _____

Date _____

FAMILY HISTORY:

Do you feel that your family history has had an affect on your current condition?

Yes No

If yes, explain why _____

Are your parents alive?

Yes No

If deceased at what age? Mother _____ Cause of death? _____

Father _____ Cause of death? _____

Are your parents healthy?

Yes No

If not what conditions do they have? Mother _____

Father _____

Do you have brothers and sisters?

Yes No

How many? Brothers? _____ Ages? _____ Sisters? _____ Ages? _____

Are they healthy? Brothers Yes No Sisters Yes No

If not healthy what illnesses do they have? Brothers? _____

Sisters? _____

Are they alive?

Yes No

If not at what ages did they die and what was the cause of death?

Brothers? Ages? _____ Cause of death? _____

Sisters ? Ages? _____ Cause of death? _____

Do you have children?

Yes No

How Many? _____ Boys _____ Ages _____ Girls _____ Ages _____

Are they all healthy?

Yes No

If not healthy, what illness do they have? _____

SOCIAL HISTORY:

What is your **occupation**? _____

Do you feel that your **Social History** has had an effect on your current condition? **Yes** **No**

Do you drink **alcoholic** beverages? **Yes** **No**

Do you use **tobacco** products? **Yes** **No**

Do you use **recreational drugs**? **Yes** **No**

Do you drink beverages with **caffeine**? **Yes** **No**

Do you take **vitamin** supplements? **Yes** **No**

Why? _____

Do you go to a **Gym or Health Club**? **Yes** **No**

Why? _____

Do you drink **Bottled water**? **Yes** **No**

Why? _____

PAST MEDICAL HISTORY:

Have you been to a **Chiropractor**? **Yes** **No**

How Long Ago? _____ Name of Chiropractor? _____ Do Not Recall

What were you treated for? _____

Do you have any **drug or other allergies**? **Yes** **No**

What drugs? _____

Do you have any **other allergies**? **Yes** **No**

What are they? _____

Other than for your current problem, have you been **hospitalized** in the past **five years**?

Yes **No**

Date / / Reason _____

How Long ? _____

Have you had any other accidents?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Slip and Fall	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Workers Compensation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Auto?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes please describe: <input type="text"/>		
Describe any treatment:		

Have you had any significant health problems in the past? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If you have had any of the following health problems in the past please check any of the following that may pertain to you. If not continue to the next topic.		
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Surgery/Pace Maker	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Stroke	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Artificial Valves
<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Shingles	<input type="checkbox"/> Cancer
<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Anemia
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Rheumatic Heart
<input type="checkbox"/> Frequent Neck Pain	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Ulcers
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Severe/Frequent Headaches	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Fainting/Seizures/Epilepsy	<input type="checkbox"/> Artificial Bones/Joints	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Lower Back Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Colitis
<input type="checkbox"/> Other-Describe: <input type="text"/>		

WOMEN ONLY

To the best of your knowledge are you pregnant? Yes No

Have your past pregnancies been normal? Yes No

If not, why? _____

I have never been pregnant. Yes No

Do you consult an OB/GYN regularly? Yes No

If Yes what is the OB/GYN's Name? _____

Date of Onset of your Current Condition? When did it start? / /

Description of Accident/Injury/Condition?

How did it happen?

Type: Automobile Accident Slip/Fall Accident

Pedestrian Accident Workmen's Compensation

Not an Accident -Explain _____

Were you treated by any other doctors for this condition? Yes No

Name of treating doctors and Specialists: _____

Are you currently taking any medications? Yes No

Anti-Inflammatory Tranquilizers Insulin Injection Diabetes medication Pills

Muscle Relaxants Pain Medication Antibiotics Blood Thinners

Thyroid Medication Birth Control Pills Blood Pressure Medications

Other List: _____

Please complete the following indicating those items that pertain to your current health:

- | | | |
|---|---|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Surgery/Pace Maker | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Artificial Valves |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Shingles | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Heart |
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Severe/Frequent Headaches | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Other-Describe: _____ | | |

Did you receive treatment in a hospital for your current condition? Yes No

When did you go to the hospital? **Immediately** **Next day** **Days later**
 Later that day

How did you get to the hospital? **Ambulance** **Police** **Drove Self** **Someone else**

What hospital **emergency room** were you taken to?

Were you **admitted**? Yes No How many days were you hospitalized?

What treatment was given?

- Oral Medication Injection Topical Antiseptics Bandages Sutures
 Ice Packs Hot Packs Splint Cast Brace
 Collar Surgery-explain_____

Were x-rays taken? Yes No Taken by? Doctor Hospital Radiologist

Areas x-rayed?

- Head Neck Upper/mid back Lower back
 Shoulder Elbow Wrist Hand
 Hip Arm Knee Ankle

Were MRI's performed? Yes No Taken by? Doctor Hospital Radiologist

Areas?

- Head Neck Upper/mid back Lower back
 Shoulder Elbow Wrist Hand
 Hip Arm Knee Ankle

Were CT scans performed? Yes No Taken by? Doctor Hospital Radiologist

Areas?

- Head Neck Upper/mid back Lower back
 Shoulder Elbow Wrist Hand
 Hip Arm Knee Ankle

Instructions given at discharge?

- no further care necessary See Chiropractor See family doctor
 See Physical Therapist See Neurologist See Orthopedist
 Use Ice No Work Take Pain medication
 Take Anti-inflammatory Take Tranquilizers Take Antibiotics
 Use Heat Rest None

If you had these symptoms before please describe:

[Redacted]

DIFFICULTY IN:

- Bending Standing Walking Lying Reaching
 Lifting Twisting Coughing Sitting Sneezing
 Rising to walk after sitting or lying down

PAIN IS RELIEVED BY:

- Rest Nothing Ice Heat Sitting
 Aspirin Advil Standing Exercise Tylenol

SYMPTOMS ARE:

- Improving Slowly Improving Moderately Improving Greatly
 Recurrent Getting Worse Not Improving

Have you missed work due to this accident/condition? Missed No Work Limited

Work Activity Missed Work From [Redacted] / [Redacted] / [Redacted] to [Redacted] / [Redacted] / [Redacted]

I **Have** **Have Not** had these symptoms before.

I **Was** **Was Not** symptomatic prior to the start of this condition or injury.

Did you self treat your symptoms? Yes No

- Ice Heat Bed Rest Over-The-Counter Medication

ACTIVITIES OF DAILY LIVING GENERAL PAIN DISABILITY INDEX

The rating scales are designed to measure the degree to which several aspects of the patient's life are presently disrupted by acute or chronic pain. In other words, we determine how much the pain the patient is experiencing is preventing the patient from doing what would normally be done, or-from doing it as well as the patient normally would. Each category was responded to by indicating the overall impact of pain in the patient's life, not just when the pain is at its worst.

For each of the six categories of daily living listed, the patient write the number, which best described the typical level of activities.

A score of 0 means no disruption in functioning at all, and a score of 10 signifies that all of the activities in the specific category in which the patient would normally be involved have been totally disrupted or prevented by the pain.

FAMILY/HOME RESPONSIBILITIES: This category refers to activities related to the home or family. It includes chores and duties performed around the house and errands or favors for other family members (e.g., driving the children to school, Travel, Driving, Riding as a passenger, Driving for more than 15-20 minutes, Riding as a passenger for more than 15-20 minutes, Sitting, Climbing stairs, Getting in/out of auto, Kneeling, Lifting children, Using telephone, Using computer, Yard Work, Mowing lawn, Raking leaves, Gardening, Housework, Doing Laundry, Making beds, Bending, Running, Walking, Walking for long distance, Sitting for long periods of time, Lifting more than a few pounds, Vacuuming, Washing dishes, Ironing, Carrying groceries, Caring for pets, Cooking.)

The patient indicated that Family/Home Responsibilities were affected at a level of ____.

RECREATIONAL ACTIVITIES: This category includes hobbies, Reading, Playing piano, Exercising, Swimming, sports and other similar leisure time activities.

The patient indicated that Recreation Activities were affected at a level of ____.

SOCIAL ACTIVITY: This category refers to activities, which involve participation with friends and acquaintances other than family members, it includes parties, theater, concerts, dining out, and other social functions.

The patient indicated that Social Activities were affected at a level of ____.

OCCUPATIONAL ACTIVITIES: This category refers to activities that are a part of our directly related to one's job. This includes non-paying jobs as well, such as that of a homemaker or volunteer worker.

The patient indicated that Occupational Activities were affected at a level of ____.

SELF CARE ACTIVITIES: This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, Personal Grooming, Combing hair, Shaving, In/out bathtub, Brushing teeth, Getting dressed, etc.)

The patient indicated that Social Care Activities were affected at a level of ____.

LIFE-SUPPORT ACTIVITY: This category refers to basic life-supporting behaviors such as eating, sleeping, Lying in bed, Chewing, Sitting in recliner and breathing.

The patient indicated that Life-Support Activities were affected at a level of ____.

The above Activities of Daily Living Pain Indexes totaled

By dividing the sum total of all the Activities of Daily Living Ratings by the total of possible Total Disability you arrive at a percentage of Total Activities of Daily Living Disability. The patient was given a Activities of Daily Living General Pain Disability Index Questionnaire on _____ and had a score of ____/60 and a percentage of General Pain Disability of ____% . The percentage of disability is rated 0-20%, No Disability to Minimal disability, 21-40% Moderate disability, 41-60% Severe disability, 61-80% Crippling disability, 81-100% Bed-bound or Exaggerating.

INITIAL COMPLAINTS

PAIN SCALE - BASED ON A SCALE OF 0 TO 10, WITH 10 BEING THE MOST SEVERE,
PLEASE RATE EACH SYMPTOM ACCORDINGLY.

JAW PAIN: Right Left **Both** **Jaw Pops** Right Left Both

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

NECK PAIN: Right Left Both

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

PAIN INCREASED BY MOVEMENT:

ROTATION Right Left

BENDING Forward Backward Right Left

Neck Stiffness Muscle Spasm Grinding and Grating Sounds

Constant Frequent Occasional Intermittent

HEADACHES:

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

LOCATED:

Front Back Temples Forehead Behind Eyes

Constant Frequent Occasional Intermittent

SHOULDER PAIN: Right Left Both

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

SHOULDER LIMITED MOVEMENT: Right Left Both

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

ARM PAIN: Right Left Both Forearm Upper Arms

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

ARM NUMBNESS: **Hand** Right Left Both **Arm** Right Left Both

DEGREE SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

ARM PINS/NEEDLES:

Hand Right Left Both **Arm** Right Left Both

DEGREE SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

ARM WEAKNESS:

Hand Right Left Both **Arm** Right Left Both

DEGREE SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

ELBOW Right Left Both

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

WRIST

Right Left Both

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

HAND PAIN:

Right Left Both

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

HAND PINS/NEEDLES:

Hand Right Left Both **Arm** Right Left Both

DEGREE SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

HAND NUMBNESS:

Hand Right Left Both **Arm** Right Left Both

DEGREE SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

HAND WEAKNESS:

Hand Right Left Both **Arm** Right Left Both

DEGREE SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

UPPER BACK PAIN: Right Left Both

SPASM Right Left Both

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

LOWER BACK PAIN: Right Left Both

SPASM Right Left Both

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

SACRO-ILIAC: Right Left Both

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

HIP PAIN: Right Left Both

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

BUTTOCK PAIN Right Left Both

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

LEG PAIN Right Left Both

RADIATING TO THE Knee Calf Foot

DOWN THE Front Back Side

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

LEG NUMBNESS Right Left Both

DEGREE SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

LEG PINS & NEEDLES Right Left Both

DEGREE SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

LEG WEAKNESS Right Left Both **in the** Thigh Calf

DEGREE SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

KNEE PAIN Right Left Both

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

ANKLE PAIN Right Left Both

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

FOOT PAIN Right Left Both

PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

FOOT PINS & NEEDLES

Right Left Both

DEGREE SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

FOOT WEAKNESS

Right Left Both **in the** Thigh Calf

DEGREE SCALE 0 1 2 3 4 5 6 7 8 9 10

Mild Mild to Moderate Moderate Moderate to Severe Severe

Constant Frequent Occasional Intermittent

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Name (Print) Date / / Signature

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