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** **No**

Slip and Fall **Yes** **No**

Workers Compensation? **Yes** **No**

Auto? **Yes** **No**

If Yes please describe:

Describe any treatment:

Have you had any significant **health problems** in the past? **Yes** **No**

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.

Heart Attack	Heart Surgery/Pace Maker	Heart Murmur
Stroke	Mitral Valve Prolapse	Artificial Valves
Congenital Heart Defect	Venereal Disease	Hepatitis
Alcohol Abuse	Shingles	Cancer
Drug Abuse	Emphysema	Anemia
HIV/AIDS	Glaucoma	Rheumatic Heart
Frequent Neck Pain	Psychiatric Problems	Ulcers
High Blood Pressure	Kidney Problems	Asthma
Low Blood Pressure	Sinus Problems	Chemotherapy

Severe/Frequent Headaches Difficulty Breathing Arthritis

Fainting/Seizures/Epilepsy Artificial Bones/Joints Tuberculosis

Lower Back Problems Diabetes Colitis

Other-Describe:____

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:

Heart Attack Heart Surgery/Pace Maker Heart Murmur

Stroke Mitral Valve Prolapse Artificial Valves

Congenital Heart Defect Venereal Disease Hepatitis

Alcohol Abuse Shingles Cancer

Drug Abuse Emphysema Anemia

HIV/AIDS Glaucoma Rheumatic Heart

Frequent Neck Pain Psychiatric Problems Ulcers

High Blood Pressure Kidney Problems Asthma

Low Blood Pressure Sinus Problems Chemotherapy

Severe/Frequent Headaches Difficulty Breathing Arthritis

Fainting/Seizures/Epilepsy Artificial Bones/Joints Tuberculosis

Lower Back Problems Diabetes Colitis

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:

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 / / to / /

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 and 0 being no pain. 1-2=Mild 3-4=Mild to Moderate 5-6=Moderate 7-8+ Moderate to Severe 9-10=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 W**EAKNESS:**

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 W**EAKNESS:**

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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