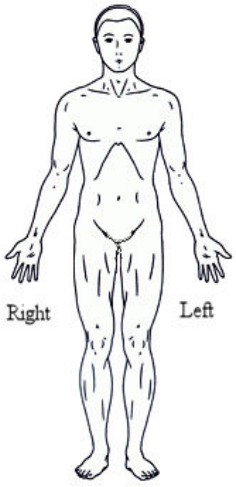
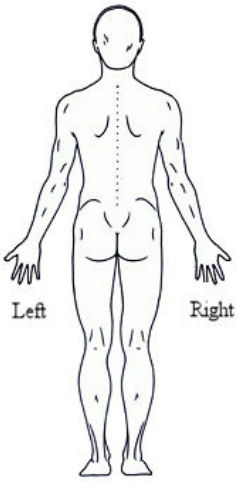
Patient History Form

Current Condition
(Primary):_____
_____

(Secondary):_____
Please mark on the figure where the pain(s) occur:





Rate the pain (primary condition): 0 1 2 3 4 5 6 7 8 9 10 (0= no pain 10 = take me to the hospital)
(secondary condition): 0 1 2 3 4 5 6 7 8 9 10

Is the pain (primary): Sharp Dull Aching Constant Intermittent
(secondary) Sharp Dull Aching Constant Intermittent
Has this condition occurred before?: _____ Does the pain radiate?_____
Are there symptoms that go along with this condition?_____
_____
Is the condition getting better or worse?_____
Is there a time of day that makes the pain worse?_____
Is there an activity that makes the pain worse?_____
Is there anything that makes the pain better?_____
Are you taking any medications for the pain?_____
Is the pain interfering with any daily activities?_____
_____
Is the condition getting better or worse?_____
Have you had previous interventions for this(these) condition(s)?_____
_____
What medications are you taking?_____
_____
Significant health issues with family members:_____
_____

Cannon Pointe Chiropractic

Patient History Form

Please mark each item below for each sign or symptom you presently have or previously had:

P=previously C=currently D=distant past F=Family History

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.
Patient
Signature_____Date_____