True Health Chiropractic

PATIENT HISTORY

Please print.

Date: _____ Referred by: _____
Name: _____ Home Phone:_____ Cell:_____
E-mail address: _____ Social Security No.: _____ Driver's License No.:_____
Address: _____ City: _____ State: ____ Zip: _____
Birth date: _____ Gender: ____ Marital Status: ___ Married ___ Single ___ Divorced ___ Widow/Widower
Occupation: _____ Employer: _____
Employer's Address: _____ Work Phone: _____
Spouse's Name: _____ Occupation: _____

MAJOR COMPLAINT(S): _____
When did you first notice the symptom(s)?_____ Are they: ____ worse ____ better ____ unchanged
Have you had this or a similar complaint before? ___ No ___ Yes. If yes, when? _____
Is your current complaint related to: ___ Work accident ___ Auto accident ___ Other accident: _____

PAST OR CURRENT CONDITIONS **(Use "P" for Past and "C" for Current):**

___Fractured bones
___Auto accidents
___Other accidents/Falls
___Mental or emotional disorders
___Arthritis
___Diabetes
___Swollen or painful joints
___Convulsions/Epilepsy
___Skin problems
___Bruise easily
___Cancer
___Frequent colds/flu
___Nervous/Tensed/Stressed
___Depressed
___Irritable
___Anemia
___Allergies
___Sinus problems
___Eating disorders

___Trouble sleeping
___Trouble concentrating
___Learning disability
___Headache
___Neck pain/stiffness
___Shoulder pain
___Dizziness
___Ringing in ears
___Fainting
___Loss of balance
___Vision problems
___Back pain/stiffness
___Numbness/tingling/pain in arms, hands, legs, feet
___Pain with coughing, sneezing or straining at stools

___Chest pain
___Asthma
___Lung problems
___Difficult breathing
___Heart problems
___High/low blood pressure
___Liver problems
___Gal bladder problems
___Digestive/bowel problems
___Ulcers
___Hemorrhoids
___Prostate problems
___Kidney/urinary problems
___Discharge
___Menstrual problems
___Breast pain
___Bed wetting
___Ear infections
___Venereal disease
___AIDS/HIV

What surgeries, if any, have you had? _____
What drugs, if any, do you now take (prescription and non-prescription)? _____
What vitamin and/or nutritional supplements do you take? _____
Do you smoke? ___ No ___ Yes. If yes, how much per day? _____
How much liquor do you consume on a weekly basis? _____
How much coffee do you consume on a daily basis? _____ Soft drinks? _____

Women: To the best of your knowledge, are you pregnant? ___Yes ___No ___Not sure

I certify that I have accurately answered the above questions to the best of my knowledge.
I give True Health Chiropractic and its representatives permission to communicate with me via the contact information above.

_____ _____
Signature of patient (or parent/guardian if a minor) Date