Back 2 Wellness CHIROPRACTIC

First ____ MI ____ Last ____ Date of Birth ____ Date ____

Street Address ____ City ____ State ____ Zip ____

Phone ____ Cell ____ E-Mail ____

CHIEF COMPLAINT ____

HISTORY OF PRESENT ILLNESS:

Location	____ (Where is the pain/problem)	**Quality**	____ (Normal v Abnormal Color, Activity, etc.)
Severity	____ (How severe 1-10)	**Duration**	____ (When did it start, How long have you had it)
Timing	____ (Does the pain/problem occur at a certain time)	**Context**	____ (Where were you at the onset of the pain/problem)
Associated Signs/Symptoms	____ (What other associated problems have you been having)	**Modifying Factors**	____ (What makes the pain worse/better; Have you had previous episodes)

PAST MEDICAL HISTORY Have you ever had the following: (check yes or no, leave blank if uncertain)

Measles	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Back Trouble	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Mumps	☐ Yes ☐ No	Bladder Infections	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Ulcer(s)	☐ Yes ☐ No
Chickenpox	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Whooping Cough	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	Hemorrhoids	☐ Yes ☐ No	Bleeding Tendency	☐ Yes ☐ No
Scarlet Fever	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Last Chest X-Ray	____	Any other disease(s)	☐ Yes ☐ No
Diphtheria	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	(please list)	
Smallpox	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Hives/Eczema	☐ Yes ☐ No		
Pneumonia	☐ Yes ☐ No	Polio	☐ Yes ☐ No	AIDS/HIV+	☐ Yes ☐ No	____	
Rheumatic Fever	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Infectious Mono	☐ Yes ☐ No		
Heart Disease	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Bronchitis	☐ Yes ☐ No	____	
Arthritis	☐ Yes ☐ No	Blood/Plasma Transfusions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Venereal Disease	☐ Yes ☐ No			Stroke	☐ Yes ☐ No	____	

PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESSES	DATE	HOSPITAL / CITY / STATE

MEDICATIONS (include non-prescriptions) ____

Have you ever taken Fen-Phen/Redux: ☐ Yes ☐ No

PATIENT SOCIAL HISTORY

Marital Status:	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Use of Alcohol	☐ Never	☐ Rarely	☐ Moderate	☐ Daily	
Use of Tobacco	☐ Never	☐ Previously but quit	☐ Current (Packs/Day) ____		
Use of Drugs	☐ Never	☐ Type ____	Frequency: ____		
Excessive Exposure to:	☐Fumes	☐ Dust	☐ Solvents	☐ Airborne Particles	☐ Noise

Profession: ____

FAMILY MEDICAL HISTORY

	Age	Disease	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

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REVIEW OF SYSTEMS: Please indicate any personal history below

☐ **Constitutional Symptoms**

Good General Health Lately	☐ Yes ☐ No
Recent weight change	☐ Yes ☐ No
Fever	☐ Yes ☐ No
Fatigue	☐ Yes ☐ No
Headaches	☐ Yes ☐ No

☐ **Eyes**

Eye Disease or Injury	☐ Yes ☐ No
Wear Glasses / Contacts	☐ Yes ☐ No
Blurred / Double Vision	☐ Yes ☐ No

☐ **Ears/Nose/Mouth/Throat**

Hearing Loss / Ringing	☐ Yes ☐ No
Earaches / Drainage	☐ Yes ☐ No
Chronic sinus problem/rhinitis	☐ Yes ☐ No
Nose bleeds	☐ Yes ☐ No
Mouth sores	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No
Bad breath or bad taste	☐ Yes ☐ No
Sore throat or voice change	☐ Yes ☐ No
Swollen glands in neck	☐ Yes ☐ No

☐ **Cardiovascular**

Heart trouble	☐ Yes ☐ No
Chest pain or angina pectoris	☐ Yes ☐ No
Palpitation	☐ Yes ☐ No
Shortness of breath w/walking or lying flat	☐ Yes ☐ No
Swelling of feet, ankles or hands	☐ Yes ☐ No

☐ **Respiratory**

Do you have a persistent cough or throat clearing not associated with a known illness lasting more than 3 weeks?	☐ Yes ☐ No
Spitting up blood	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No

☐ **Gastrointestinal**

Loss of appetite	☐ Yes ☐ No
Change in bowel movements	☐ Yes ☐ No
Nausea or vomiting	☐ Yes ☐ No
Frequent diarrhea	☐ Yes ☐ No
Painful bowel movements or constipation	☐ Yes ☐ No
Rectal bleeding or blood in stool	☐ Yes ☐ No
Abdominal pain	☐ Yes ☐ No

☐ **Genitourinary**

Frequent urination	☐ Yes ☐ No
Burning or painful urination	☐ Yes ☐ No
Blood in urine	☐ Yes ☐ No
Change in force while urinating	☐ Yes ☐ No
Incontinence or dribbling	☐ Yes ☐ No
Kidney stones	☐ Yes ☐ No
Sexual difficulty	☐ Yes ☐ No
Male – Testicle pain	☐ Yes ☐ No
Female – pain with periods	☐ Yes ☐ No
Female – irregular periods	☐ Yes ☐ No
Female – vaginal discharge	☐ Yes ☐ No
Female - # of pregnancies	________
Female - # of miscarriages	________
Female – date of last pap smear	________

☐ **Musculoskeletal**

Joint pain	☐ Yes ☐ No
Joint stiffness or swelling	☐ Yes ☐ No
Weakness of muscles or joints	☐ Yes ☐ No
Muscle pain or cramps	☐ Yes ☐ No
Back pain	☐ Yes ☐ No
Cold extremities	☐ Yes ☐ No
Difficulty in walking	☐ Yes ☐ No

☐ **Integumentary (skin, breast)**

Rash or itching	☐ Yes ☐ No
Change in skin color	☐ Yes ☐ No
Change in hair or nails	☐ Yes ☐ No
Varicose veins	☐ Yes ☐ No
Breast pain	☐ Yes ☐ No
Breast lump	☐ Yes ☐ No
Breast discharge	☐ Yes ☐ No

☐ **Neurological**

Frequent or recurring headaches	☐ Yes ☐ No
Light headed or dizzy	☐ Yes ☐ No
Convulsions or seizures	☐ Yes ☐ No
Numbness or tingling sensation	☐ Yes ☐ No
Tremors	☐ Yes ☐ No
Paralysis	☐ Yes ☐ No
Head injury	☐ Yes ☐ No

☐ **Psychiatric**

Memory loss or confusion	☐ Yes ☐ No
Nervousness	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Insomnia	☐ Yes ☐ No
Suicidal Thoughts	☐ Yes ☐ No
Violent or Unusual Thoughts	☐ Yes ☐ No

☐ **Endocrine**

Glandular or hormone problem	☐ Yes ☐ No
Excessive thirst or urination	☐ Yes ☐ No
Heat or cold intolerance	☐ Yes ☐ No
Skin becoming dryer	☐ Yes ☐ No
Change in hat or glove size	☐ Yes ☐ No

☐ **Hematologic/Lymphatic**

Slow to heal wounds	☐ Yes ☐ No
Bleeding or bruising tendency	☐ Yes ☐ No
Anemia	☐ Yes ☐ No
Phlebitis	☐ Yes ☐ No
Past transfusion	☐ Yes ☐ No
Enlarged glands	☐ Yes ☐ No

☐ **Allergic/Immunologic**

History of Skin reaction or other adverse reaction to:

Penicillin or other antibiotics	☐ Yes ☐ No
Morphine, Demerol or other narcotics	☐ Yes ☐ No
Novocain or other anesthetics	☐ Yes ☐ No
Aspirin or other pain remedies	☐ Yes ☐ No
Tetanus antitoxin or other serums	☐ Yes ☐ No
Iodine, Merthiolate or other antiseptic	☐ Yes ☐ No

Other drugs/medications

____

____

Known food allergies

____

____

Environmental allergies

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

________________________________ ________________

Signature of Patient, Parent or Guardian **Date**

Doctor's Review

________________________________ ________________

Signature of Doctor Date