Patient Name:_____DOB:_____

CHIEF COMPLAINT Please briefly describe the purpose of this visit, and specifically what you want to achieve from it.	**Physician Notes**
HISTORY OF PRESENT CONCERN(S)	**NOTES**
What concerns are you experiencing?	
What part(s) of your body does this concern affect?	
How long have you had this problem?	
How often does the problem occur?	
Does the problem occur at a particular time of day? If so, when?	
How long does the problem last?	
How severe is the problem? Does it affect your activities of daily living?	
Does anything help make the problem go away? If so, what?	
Does anything seem to make the problem worse? If so, what?	
List all the tests you have had for this problem (Blood, Urine, MRI, CT Scan, EMG, EEG).	
List the prior treatment or surgery for this problem and if has helped?	
How much pain have you had in the past week? (no pain 0 to maximal 10) 0……1……..2.....3……..4.....5.....6.....7.....8……..9……..10 _____ 10	

Patient Name:_____DOB:_____

REVIEW OF SYSTEMS - GENERAL Please check any conditions you have experienced.							
GENERAL		**EARS, NOSE, MOUTH, THROAT**		**CARDIOVASCULAR**		**HEMATOLOGIC/ENDOCRINE**	
	Altered taste/ smell		Balance problem		Angina		Blood disorder
	Change in appetite		Dizziness		Chest pain		Diabetes
	Weight loss		Ringing in ears		Chest pressure		Other Endocrine disorder
	Weight gain		Hearing loss		Fainting		Anemia
	Unable to sleep		Trouble breathing through nose		Heart Failure		Thyroid Disease
	Excessive sleepiness		Nose bleeds / discharge		Heart Murmur		Enlarged lymph nodes
	Snoring		Sinus disease		High blood pressure		HIV exposure
	Skip breathing in sleep		Mouth sores		Low blood pressure		AIDS
	Excessive Sweating				Shortness of breath		Dry eyes or dry mouth
	Fever		Trouble swallowing		Leg swelling		Miscarriages
MUSCULOSKELETAL		**EYES**		**GASTROINTESTINAL**		**RESPIRATORY**	
	Low back pain		Blurred vision		Abdominal pain		Bronchitis
	Neck pain		Double vision		Constipation		Emphysema
	Joint pain		Glaucoma		Diarrhea		Pneumonia
	Joint swelling		Cataracts		Bloating/Gas		Tuberculosis
	Joint replacement				Hepatitis		Chronic cough
SKIN		**PSYCHIATRIC**			Hiatal Hernia		**URINARY**
	Breast disease		Anxiety		Rectal bleeding		Increased frequency
	Skin rash		Depression		Ulcer		Incontinence
	Botox injection		Trouble concentrating		Vomiting		Sexual dysfunction
REVIEW OF SYSTEMS – NEUROLOGIC							
	Confusion		Clumsiness		Choking		Difficulty with smelling
	Difficulty Concentrating		Facial numbness / tingling		Difficulty chewing		Double vision
	Dizziness		Numbness - arms (L/ R/ Both)		Difficulty tasting		Trouble swallowing
	Hallucinations		Numbness - legs (L/ R/ Both)		Drooling		Fainting spells
	Headache		Poor balance		Hoarseness		Vertigo/Dizziness
	Lethargy		Poor coordination		Incontinence- bowel		Muscle Twitching
	Memory problems		Speech difficulty		Incontinence- bladder		Loss of muscle bulk
	Personality change		Stiffness in limbs		Nausea		Any falls in past 1 yr.
	Seizures		Trouble walking		Shooting Pains		
	Increase/Decrease in sweating in limbs		Weakness - arms (L/ R/ Both)		Tingling sensation		
	Leg Discomfort @ Night		Weakness - legs (L/ R/ Both)		Shortness of breath		

Patient Name:_____DOB:_____

Please list all medical problems and hospitalizations you had in the past with approximate dates.
(Use separate page if necessary.)

MEDICAL PROBLEMS	DATE	LOCATION/FACILITY	RESULT

SURGERIES (Please list all operations you have had, with approximate dates)

PROCEDURE	DATE	FACILITY	RESULT

Have you ever seen a chiropractor before? ☐ Yes ☐ No
If so, describe his/her treatments?

Have you ever had a spinal adjustment/manipulation? Yes ☐ No ☐
If so, by whom and how did it make you feel?

Patient Name:_____DOB:_____

FAMILY HISTORY							
	Father	Mother	Father's Parents	Mother's Parents	Brothers / Sisters	Children	NOTES
Arthritis							
Bleeding disorder							
Cancer							
CNS Tumors							
Dementia							
Diabetes							
Epilepsy							
Heart Disease							
Hypertension							
Kidney Disease							
Lupus							
MS							
Neuropathy/ALS/muscular dystrophy							
Stroke							
Thyroid Disease							

GYN/ OB MEDICAL HISTORY

LAST MENSTRUAL PERIOD: ARE YOU POST-MENOPAUSAL? ☐ YES ☐ NO DATE OF MENOPAUSE:

DATE OF LAST GYNECOLOGICAL EXAM WITH PAP SMEAR: RESULT:

DATE OF LAST MAMMOGRAM: RESULT:

HAVE YOU EVER BEEN PREGNANT? ☐ YES ☐ NO IF SO, HOW MANY TIMES? _____
HOW MANY DELIVERIES HAVE YOU HAD? _____ HAVE YOU EVER HAD A MISCARRIAGE? ☐ YES ☐ NO

Patient Name:_____DOB:_____

SOCIAL HISTORY

HOW OLD ARE YOU? HEIGHT: WEIGHT: ARE YOU A TWIN? Y N

ARE YOU: __ LEFT-HANDED __ RIGHT-HANDED __ BOTH

ARE YOU: __ SINGLE __ MARRIED __ WIDOWED __ SEPARATED __ DIVORCED

WHAT IS YOUR OCCUPATION?

DO YOU LIVE: __ ALONE __ WITH SPOUSE __ WITH ROOMMATE __ WITH PARENTS/SIBLINGS _OTHER_

WHAT IS YOUR HIGHEST LEVEL OF EDUCATION?
__ GRADE SCHOOL __ HIGH SCHOOL __ VOCATIONAL SCHOOL __ COLLEGE __ GRADUATE SCHOOL

WHAT ARE YOUR HOBBIES?

DO YOU SMOKE? __YES __NO HOW MUCH? _____ PER _____ FOR HOW LONG? _____
HAVE YOU EVER SMOKED? __YES __NO HOW MUCH? _____ PER _____ FOR HOW LONG? _____
WHEN DID YOU STOP?

DO YOU DRINK ALCOHOL? __YES __NO HOW MUCH? ___ PER ___ FOR HOW LONG? _____
HAVE YOU EVER DRUNK ALCOHOL? __ YES __NO HOW MUCH? ___ PER ___ FOR HOW LONG? _____
WHEN DID YOU STOP?

Patient Name:_____DOB:_____

ALLERGIES: Please list any medication allergies and your reaction to these medications:

1._____ 3._____

2. _____4. _____

MEDICATIONS (include over-the-counter and herbal medications)	DOSE (e.g., strength, # of pills or drops)	ROUTE (e.g., by mouth, injection, inhaled, orn skin)	FREQUENCY (how often)
Example: Vitamin C	*500 mg*	*By mouth*	*Once a day*
1.			
2.			
3.			
4.			
5			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Please use additional sheet for more medications.