PATIENT HISTORY – Winchester Family Chiropractic, PLLC

Today's Date: _____ E/M Level IV HRN: _____

PATIENT DEMOGRAPHICS

EMAIL ADDRESS:_____

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Fax: _____

Mobile Phone: _____ Work Phone: _____ Fax: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Name of Spouse: _____ Spouse's Employer: _____

Occupation: _____ Names and Ages of your children: _____

Name & Number of Emergency Contact: _____Relationship: _____

HISTORY of COMPLAINT(s)

Please list in order of importance all complaints and the symptoms you are currently experiencing that brought you to this office:

Primary problem _____ 2nd _____ 3rd _____ 4th_____

When did each **problem/symptom begin**: Primary complaint _____ 2nd _____ 3rd _____ 4th_____

Number of times you have experienced: Primary complaint _____ 2nd _____ 3rd _____ 4th_____

When was the last **episode**? Primary complaint _____ 2nd _____ 3rd _____ 4th_____

What relieves your symptom(s)? Primary complaint _____ 2nd _____ 3rd _____ 4th_____

What makes them feel worse? Primary complaint _____ 2nd _____ 3rd_____ 4th_____

Please mark with a "**C**" if you feel your pain constantly or an "**I**" if you experience it intermittently on the line next to each compliant:

Primary problem ___ 2nd ___ 3rd ___ 4th ___ 5th____

On a scale of **1 to 10** with**10** being the worst pain and **0** being no pain, rate how you feel today ***(Circle the number)***:

Primary or chief complaint	0	1	2	3	4	5	6	7	8	9	10
Second complaints	0	1	2	3	4	5	6	7	8	9	10
Third complaint:	0	1	2	3	4	5	6	7	8	9	10
Fourth complaint:**:**	0	1	2	3	4	5	6	7	8	9	10
Fifth	0	1	2	3	4	5	6	7	8	9	10

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms: **R = R**adiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

Do your symptoms cause you to feel worse in the ☐ AM ☐ PM ☐ mid-day ☐ late PM

Have these Problems ever been treated by anyone in the past? ☐No ☐Yes **If yes**

Who provided: _____

How long ago? _____What **type** of treatment did you receive? _____

What were the **results?** ☐ Favorable ☐ Unfavorable → **If unfavorable** please explain:

_____

List any **medications** taken to treat these conditions:_____

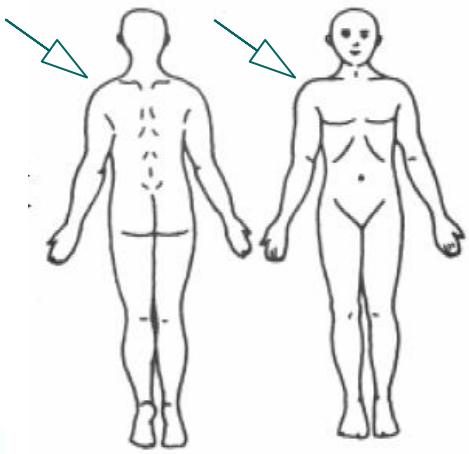
Did they help? ☐ No ☐ Yes If you still take them, how often? _____

Have you ever been under chiropractic care? ☐ No ☐ Yes **If yes,** how long ago: _____

Name of Previous Chiropractor: _____

Are any of your problem(s) today the result of ANY **recent accident**? ☐ No ☐ Yes **If yes,**

How long ago? _____ Please explain what type of accident: _____



PAST HISTORY

1. If you have ever been diagnosed with any of the following conditions please indicate with a **P** for in the **Past, C** for **Currently** have and **N** for **Never** have had:

___ Heart Attack ___ Dislocations ___ Tumors ___ Stroke ___ Seizure

___ Broken Bone ___ Concussion ___ Disability ___ Cancer ___ Rheumatoid Arthritis

___ Osteo Arthritis ___ Fracture ___ Diabetes ___ Other serious conditions {*Doctors add other possible contraindications here*}

2. PLEASE**, identify** ALL PAST **and or any** unrelated current **conditions you feel may be contributing your present problem:**

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
REVIOUS ACCIDENTS:			
ADULT DISEASES:			
SURGERIES:			
CHILDHOOD DISEASES:			

Patient Name: _____

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes **If yes whom**:
❑ Grandmother ❑ Grandfather ❑ Mother ❑ Father ❑ Sister's ❑ Brother's ❑ Son(s) ❑ Daughter(s)
2. Have they ever been treated for their condition? ❑ No ❑ Yes ❑I don't know
3. Any other hereditary conditions the doctor should be aware of ❑ No ❑Yes _____

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. **How** many years of school did you complete? ❑ 1-8 ☐ 8-12 ☐ 12-14 ☐ 14-16 ☐ 16 +

5. Please mark with an X under columns 3, 4, 5and 6, the effect your current condition is having on your ability to perform the activity

COLUMNS→		3	4	5	6
Related Pain Scale		1 2 3	4 5 6	7 8	9 10
ACTIVITY or Movement : Measurement→					
Bending neck forward		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Bending neck backward		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Turning neck right to left		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Turning neck left to right		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Twisting from the waste		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Bending side to side		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Bending backward		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Bending forward		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Standing erect		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Going from standing to sitting		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Sitting for periods over		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Going from sitting to standing		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Standing for periods over		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Going form sitting to lying down		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Lying down for more than		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Going from lying to sitting up		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Rolling over when lying down		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Extending arms overhead		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Extending arms forward		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Pushing		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Pulling		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Shoveling		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Lifting more than		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Walking or running		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Climbing uphill (stairs, ladders)		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Walking downhill		☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform

Signature:_____ Date Completed / / Doctors Sig. _____