

**Confidential Patient History Form**

**Date:** \_\_\_\_\_

Name \_\_\_\_\_

Home Phone \_\_\_\_\_

I prefer to be called \_\_\_\_\_

Cell Phone \_\_\_\_\_

Address \_\_\_\_\_

Work Phone \_\_\_\_\_

\_\_\_\_\_

Email \_\_\_\_\_

Sex  Male  Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

Height \_\_\_\_\_' \_\_\_\_\_" Weight \_\_\_\_\_ lbs

Employer \_\_\_\_\_

Marital Status \_\_\_\_\_

No of Children \_\_\_\_\_

If minor, name of parent or guardian \_\_\_\_\_

Who should we contact in case of an emergency? \_\_\_\_\_

Relation \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ City \_\_\_\_\_

Who may we thank for referring you to this office? \_\_\_\_\_

Have you ever been to a chiropractor before?  YES  NO If so, whom? \_\_\_\_\_

1. Reason for visit (*Please circle*): **sport injury, auto accident** ( My Fault,  Not My Fault) **work accident, acute trauma, chronic condition or other:** \_\_\_\_\_

2. If this visit is due to pain, when did the symptoms begin? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

3. Please explain what you are experiencing \_\_\_\_\_

\_\_\_\_\_

4. Is the condition getting worse?  YES  NO  CONSTANT  COMES & GOES

5. List activities that aggravate the condition: \_\_\_\_\_

\_\_\_\_\_

6. List activities that are inhibited because of the condition \_\_\_\_\_

\_\_\_\_\_

7. Have you had this or a similar condition in the past?  YES  NO

8. Have you been treated by a medical physician for this condition?  YES  NO

9. Are you taking any medication for this condition?  YES  NO If yes, please list: \_\_\_\_\_

10. Are you suffering from any diseases or other conditions? If so, please describe

below \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Patient/Parent or Legal Guardian Signature:** \_\_\_\_\_



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