

Inspire Chiropractic & Wellness

Chiropractic Medical History

Name: _____

DOB: _____

What is your: Height _____

Weight: _____

1. **PRIMARY CHIEF COMPLAINT:** _____

Additional Complaints: _____

2. Complaint began when and how: _____

3. Circle all that apply to the quality of the complaint:
Dull Aching Sharp Shooting Burning Throbbing Deep Other _____

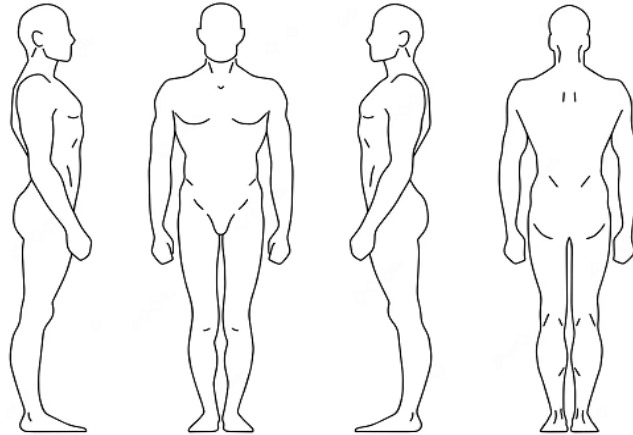
4. Is this: AUTO Related / WORK Related OR Neither

5. List all Healthcare providers in the LAST YEAR you have seen for this complaint:

6. Circle the severity of the complaint:
(No pain/complaint) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint)
<MILD> <MODERATE> <SEVERE>

7. In the past week, how much has your pain interfered with your daily activities? (e.g. work)
(No interference) 0 1 2 3 4 5 6 7 8 9 10 (Unable to carry on any activities)
<MILD> <MODERATE> <SEVERE>

8. PLEASE TRACE YOUR AREA OF COMPLAINT BELOW:



9. **COMPLAINT CHARACTERISTICS:**

A. Does this complaint radiate or travel (shoot) to any areas of your body? YES NO Where: _____

B. Do you have any numbness or tingling in your body? YES NO Where: _____

C. How frequent is complaint present, how long does it last? _____

D. Is it worse in the morning, afternoon, evening, or at rest? _____

E. What aggravates the complaint? _____

F. What relieves the complaint? _____

Date: _____

Name: _____

DOB: _____

10. Have you had any: X-Rays, MRI's, CAT Scans, NCV, EMG's, Ultrasounds, or any other diagnostic test?

When: _____ Test: _____ Body Area: _____ Where: _____
When: _____ Test: _____ Body Area: _____ Where: _____

11. Previous treatments, medications, or surgery for THIS complaint: _____

12. Past Health History:

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Currently Pregnant, # weeks: _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Stroke (date): _____ | <input type="checkbox"/> Corticosteroid Use (prednisone, cortisone) | <input type="checkbox"/> Marked Morning Pain/Stiffness |
| <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Dizziness/Fainting/Balance | <input type="checkbox"/> Pain Unrelieved by Position or Rest |
| <input type="checkbox"/> Cancer/Tumor (explain): _____ | <input type="checkbox"/> Eye/Visual Disturbances | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Prostate Problems | |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Menstrual Problems | |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Urinary Problems | |

Surgeries: _____

Problems with the following (circle): Skin, Breast, Hearing, Stomach, Intestinal, Kidney, Psychological
(explain): _____

Allergies: _____

Other Health Problems (explain): _____

13. PLEASE LIST ALL medications you are presently taking or have recently taken and the REASON:

MEDICATION: _____ REASON: _____

MEDICATION: _____ REASON: _____

MEDICATION: _____ REASON: _____

***IF MORE ROOM IS NEEDED, PLEASE USE THE BACK OF THIS SHEET**

14. Females Only:

A. # of Pregnancies: _____ # of Births: _____ Complications: _____

B. What was the start date of your **last menstrual period**? _____ *(In case X-rays or other tests are ordered)

C. Are you presently taking or using any **birth control medication or devices**? YES NO Type: _____

D. Have you had a **mammogram**? YES NO Date: _____ Results: Positive / Negative

15. Males Only:

A. Have you had a **prostate exam**? YES NO Date: _____ Results: Positive / Negative

16. Family Health History:

- Cancer Heart Problems Stroke Diabetes Rheumatoid Arthritis High Blood Pressure

A. Cause of parent(s) or sibling(s) death(s) / Age at death? _____

17. Social and Occupational History:

A. Level of Education: Grade School High School Some College College Graduate Post Graduate

B. Job Description: _____ Work Schedule: # of Hours/Week _____

C. Recreational Activities: _____

D. Lifestyle (hobbies, level of weekly exercise, diets): _____

E. Do you currently smoke or have smoked in the past? YES NO Are you still smoking? YES NO

of Packs Per Day: _____ # of Years Used: _____

F. Do you currently or have you previously used any **illegal drugs** or over utilized any **prescription medications**? YES NO

Are you still using the drug(s)? YES NO **TYPE/AMOUNT:** _____

I have read the above information and certify it to be true and correct to the best of my knowledge. I understand that it is my responsibility to update my medical history or changes in my medical health status to the doctor immediately.

Patient/Guardian Signature: _____

Date: _____

Doctor Signature: _____

Date: _____