# Inspire Chiropractic & Wellness

Chiropractic Medical History - New Patient

**Name and ID:** _____ **DOB:** _____ **Today's Date:** _____

**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)**

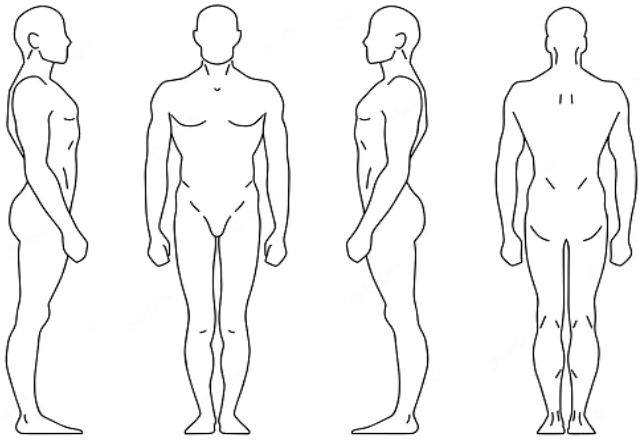
**<MILD> <MODERATE> <SEVERE>**

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? _____

_____

**Name and ID:** _____ **DOB:** _____ **Today's Date:** _____

**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 <u>THIS</u> complaint:** _____

_____

**12. <u>Past Health History:</u>**

☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date): _____
☐ Lyme Disease
☐ Cancer/Tumor (explain): _____
☐ Epilepsy/Seizures
☐ Osteoporosis
☐ Autoimmune Disease
☐ Pacemaker

☐ Recent Fever
☐ Headaches
☐ Corticosteroid Use (prednisone, cortisone)
☐ Dizziness/Fainting/Balance
☐ Eye/Visual Disturbances
☐ Arthritis
☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems

☐ Currently Pregnant, # weeks: _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night

☐ Surgeries: _____

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

(explain): _____

☐ Allergies: _____

☐ Other Health Problems (explain): _____

**13. <u>PLEASE LIST ALL</u> medications you are presently taking or have recently taken and the <u>REASON</u>:**

MEDICATION: _____ REASON: _____

MEDICATION: _____ REASON: _____

MEDICATION: _____ REASON: _____

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

**14. <u>Females Only:</u>**

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

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

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

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

**15. <u>Males Only:</u>**

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

**16. <u>Family Health History:</u>**

☐ **Cancer** ☐ **Diabetes** ☐ **Heart Disease** ☐ **Heart Failure** ☐ **High Blood Pressure** ☐ **Kidney Disease** ☐ **Stroke** ☐ **Rheumatoid Arthritis**

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

**17. <u>Social and Occupational History:</u>**

**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 **<u>illegal drugs</u>** or over utilized any **<u>prescription medications</u>**? 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 <u>my responsibility</u> to update my medical history or changes in my medical health status to the doctor immediately.**

**Patient/Guardian Signature:** _____ **Date:** _____

**Doctor Signature:** _____ **Date:** _____