Inspire Chiropractic & Wellness RESET FORM

Chiropractic Medical History - New Patient

Name: **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)**

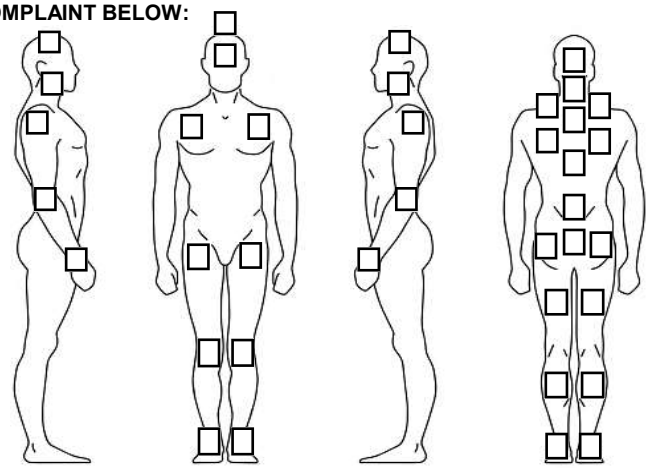
<MILD> <MODERATE> <SEVERE>

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: **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:

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:** _____

SUBMIT