Living Wise Chiropractic

Patient history form

Name_____ Age_____ Today's Date ___/___/___
Address_____City_____State____ Zip_____
Gender: Male/ Female/Other_____ Pronouns_____
Cell #_____Home#_____Work#_____
Occupation_____E-mail_____
Marital status_____ Spouse/Partner name_____
Children's name/ages_____
_____
Emergency contact_____ phone#_____

Have you previously received chiropractic treatment?_____
If yes, date of last visit?_____ How long were you in care?_____
If you stopped, why did you stop going? _____
Do you know what type of adjustments were performed or what technique/s or methods were used?_____

This chiropractic office provides care to people of all ages and walks of life. Some start care because of painful symptoms or a specific health concern, while others come into care because they are seeking to increase the quality of their lives.

Reason for seeking care today_____
_____

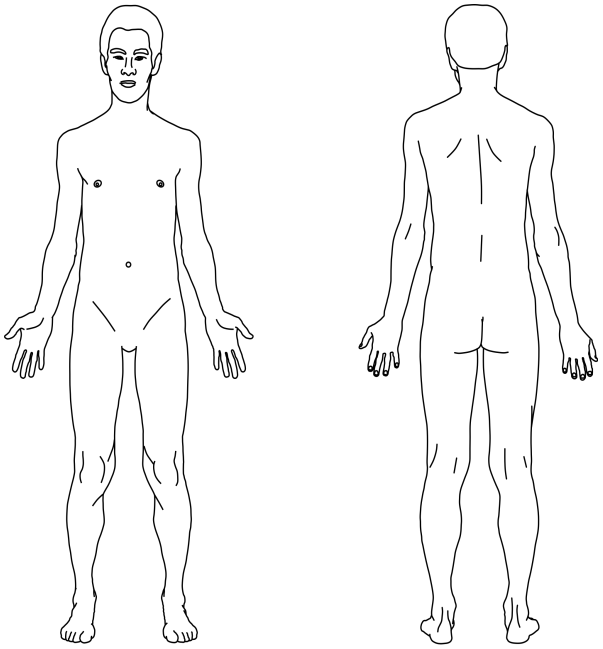
Current Health Concern (If not applicable, for example if you are here for wellness care with no current health concern/physical symptoms, skip to **Health History** on pg 3)

Please describe your concern and or symptoms and how they began?
_____
_____
_____
When did the current complaint begin? _____
How long have you had these symptoms? _____

Please circle your degree of pain with 0 being none and 10 being extreme pain.
0 1 2 3 4 5 6 7 8 9 10

Using the following symbols, mark on the pictures below where you feel symptoms:

Numbness = = = Dull Ache OOO Burning XXX Sharp/Stabbing / / /
Pins, Needles + + + Other _____ ^ ^ ^



R L L R

What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day? Y/N If yes, when?_____
Is this condition interfering with: Work?_____ Sleep?_____Routine?_____
Other?_____
Is this condition getting: Better?_____ Worse?_____ Not Changing?_____
Have you seen any other doctors or health professionals for this? Y/N
If yes, what was done?_____
Have you had similar health concerns in the past? Y/N
If yes, why do you think this has happened, or continues to happen for you?_____
_____
_____

Health History

Have you been in any vehicular accidents? If yes, please list approximate dates and severity. (mild, moderate, extreme) _____
_____
_____
Have you ever been knocked unconscious? Y/N If yes, please explain _____
_____
Have you ever been hospitalized? Y/N If yes, when and what for? _____
_____
Have you had any surgeries? Y/N If yes, when and what for? _____
_____
Have you ever broken any bones? Y/N If yes, which one/s? _____
Have you been treated for any health condition by a physician in the last year? Y/N
If yes, explain: _____
Are you currently taking medication? Y/N If yes, list medication: _____
_____
Have you taken medication for extended periods of time in the past? Y/N If yes, please list medication _____
Do you smoke Y/N Drink Alcohol Y/N _____Daily _____Weekly _____Social Occasions
How many caffeinated drinks per day _____ Do you take Vitamins/Supplements Y/N If yes, what type and how often_____
_____

Mental/ Emotional Stress Levels: please write in "**P**" for past and "**C**" for current

	Mild	Moderate	Severe
Childhood	_____	_____	_____
School	_____	_____	_____
Finances	_____	_____	_____
Relationships	_____	_____	_____
Illness	_____	_____	_____

	Mild	Moderate	Severe
Work	_____	_____	_____
Change in lifestyle	_____	_____	_____
Family	_____	_____	_____
Abuse	_____	_____	_____
Loss of loved one	_____	_____	_____

How would you grade your mental/emotional health? Excellent Good Fair Poor
How would you grade your physical health? Excellent Good Fair Poor
When you feel ill, why do you feel you are ill?_____
_____
When you feel well, why do you feel you are well? _____
_____