Date _____

Personal History Form

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

Name _____ S.S.# _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Business phone _____

Cell phone _____ e-mail address _____

Gender: □ Male □ Female Birth Date _____ Age _____

Employer _____ Occupation _____

Employment address _____

In case of emergency contact _____ Phone _____

Referred by _____ Have you ever been treated by a chiropractor before? □ Yes □ No

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How would you describe your chief complaint at this time?

_____

_____

When did it start? _____
(Include month and year, day if known)

What makes the pain worse? _____

What makes the pain better? _____

How would you describe your pain? _____

At what time of the day or week is your pain worse? _____

The pain is: □ Intermittent □ Constant

Have you had this problem in the past? _____ If so, how often? _____

How many times a week do you engage in physical activity that is sufficiently prolonged and intense to cause sweating and raise you heart rate?_____

When you engage in the physical activity noted above, what is the average duration of activity?
____ Less than 10 minutes ____ 10 – 20 mins ____ 20 – 30 mins ____ 30 – 60 mins ____ over 60 mins

When you engage in the physical activity noted above, what do you feel the level of effort is?_____

At work, how many days per week do you engage in tasks that are intense enough to cause sweating and a rapid heart rate?_____

Please rate your level of fitness (0 = very poor, 5 = average, 10 = excellent) _____

Is your pain the result of a motor vehicle accident? _____

Have you filed a legal suit? _____

Is your pain the result of a work related injury? _____

If so, have you filed a worker's compensation claim? _____

Please list accidents, injuries, surgeries, and hospitalizations you have had.

_____ Date or Age _____

_____ Date or Age _____

_____ Date or Age _____

Do you or other family members have a history of any of the following?

Arthritis	□ Self	Family member _____
Asthma	□ Self	Family member _____
Cancer	□ Self	Family member _____
Diabetes	□ Self	Family member _____
Heart Disease	□ Self	Family member _____
Hypertension	□ Self	Family member _____
Hypoglycemia	□ Self	Family member _____
Kidney Disease	□ Self	Family member _____
Depression	□ Self	Family member _____
Mental Illness	□ Self	Family member _____

Do you drink coffee or black tea? _____ If so, how much per day? _____

Do you smoke tobacco? _____ If so, how much per day? _____

Do you drink alcohol? _____ If so, how often? _____

What medications, vitamins, supplements, herbs do you take?

Name	**Reason**
_____	_____
_____	_____
_____	_____
_____	_____

Please list any allergies that you have.

_____