CHIROPRACTIC CARE CENTER
CONFIDENTIAL PATIENT HEALTH COMPLAINT FORM

First Name_____ Initial _____ Last Name_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Sex: Male / Female Email:_____

Marital Status (circle): Single / Married / Divorced / Widowed Referred by: _____

Age _____ Birthdate: ____ / ____ / _____ Occupation: _____ Employer: _____

Height _____ Weight _____ Spouse/Contact Name for Emergencies _____Phone (_____) _____

Chief Complaint: _____

Date complaint began: _____ What caused this problem? _____

Symptoms developed from: ☐ a work injury ☐ an auto accident ☐ other accident

Describe other complaints: *(please be specific)*

Involving neck & head: _____

Involving mid-back/shoulders/arms & hands: _____

Involving low back/hips/legs & feet: _____

What activities make conditions WORSE? _____

What activities made conditions BETTER? _____

Have you ever had this condition before? ☐ Yes ☐ No If yes, when? _____

Indicate ability to perform the following activities: Use codes U = Unable P = Painful L= Limited N = Normal

_____ Coughing	_____ Standing more than 1 hour	_____ Climbing	_____ Stooping
_____ Sneezing	_____ Sitting at a table	_____ Kneeling	_____ Gripping
_____ Bending forward	_____ Lying on back	_____ Balancing	_____ Pushing
_____ Turning over in bed	_____ Lying flat on stomach	_____ Dressing self	_____ Pulling
_____ Walking short distances	_____ Lying on side with knees bent	_____ Sleeping	_____ Reaching
			_____ Sexual activity

What type of recreational or exercise activities are you involved in? _____

Family History:

	DIABETES	HEART	KIDNEY	CANCER	BACK	STROKE	HIGH B.P.
Mother	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐

Women: Are you pregnant? Yes No Unsure / Possibly Date of your last menstrual cycle? (Date) _____

Check any of the following diseases you have had:

☐ Aids	☐ Malaria	☐ Chicken Pox	☐ Alcoholism	☐ Appendicitis
☐ Tuberculosis	☐ Diabetes	☐ Venereal Infection	☐ Scarlet Fever	☐ Whooping Cough
☐ Cancer	☐ Arthritis	☐ Diptheria	☐ Anemia	☐ Heart Disease
☐ Epilepsy	☐ Typhoid Fever	☐ Measles	☐ Goiter	☐ Mental Disorder
☐ Pneumonia	☐ Mumps	☐ Influenza	☐ Lumbago	☐ Rheumatic ☐ Fever
☐ Small Pox	☐ Pleurisy	☐ Eczema	☐ Polio	☐ High Blood Pressure

Check any of the following problems you have or have had in the past 6 months:

Muscles & Joints
□ Low Back Pain
□ Pain Between Shoulders
□ Neck Pain/Stiffness
□ Arm/Elbow/Wrist Pain
□ Walking Problems
□ Difficulty Chewing
□ Clicking Jaw
□ Leg/Knee/Foot Pain
□ Hip Pain
□ Pain in Tailbone

Eye, Ear, Nose & Throat
□ Vision Problems
□ Dental Problems
□ Sore Throat
□ Earaches
□ Hearing Difficulty
□ Stuffed Nose
□ Ringing in Ears
□ Nose Bleeds
□ Sinus Trouble
□ Swollen Glands
□ Bronchitis

Nervous System
□ Nervousness
□ Numbness
□ Paralysis
□ Dizziness
□ Confusion
□ Depression
□ Fainting
□ Convulsions
□ Cold Extremities

Heart & Lungs
□ Wheezing
□ Chest Pain
□ Asthma
□ Short Breath
□ High Blood Pressure
□ Low Blood Pressure
□ Irregular Heart Beat
□ Heart Surgery
□ Lung Congestion
□ Coughing
□ Spitting Blood
□Varicose Veins
□ Ankle Swelling

General Problems
□ Fatigue
□ Night Sweats
□ Frequent Colds
□ Loss of Sleep
□ Fever
□ Headaches
□ Weakness

Stomach / Intestines
□ Poor Appetite
□ Excessive Appetite
□ Excessive Thirst
□ Nausea
□ Vomiting
□ Diarrhea
□ Hemorrhoids/Piles
□ Liver Trouble
□ Gall Bladder Problems
□ Weight Trouble
□ Stomach Cramps
□ Stomach Pain
□ Gas / Bloating
□ Heartburn
□ Black/Bloody Stool
□ Colitis
□ Poor Digestion

Kidney / Bladder
□ Painful Urination
□ Excessive Urine
□ Discolored Urine
□ Bedwetting
□ Bad Urine Control

Men
□ Prostate Pain
□ Impotence
□ Infertility

Women
□ Menses Irregular
□ Menstrual Cramps
□ Vaginal Pain
□ Breast Lumps
□ Pain during sex
□ Infertility
□ Miscarriage

Have you ever been treated by a chiropractor? _____

When did you last see a doctor? _____ Last X-Rays? _____

What was the purpose of that visit? _____

Have you seen any other doctor for your present condition? ☐ Yes ☐ No

If yes, please give doctor's name and specialty: _____

Please list any surgeries you have had (include when and what for): _____

_____

Please list any medications you are currently taking and what they are for (include prescription/ over the counter/ birth control / pain reliever):

_____

_____

Habits: ☐ Smoking Packs per Day _____ ☐ Alcohol Drinks per Day _____

☐ Coffee Cups per Day _____ ☐ Soda Cans per Day _____

Please list any allergies you have: _____

Race/Ethnicity:

□ White/Caucasian □ Black/African American □ Asian
□ American Indian □ Native Hawaiian □ Hispanic/Latino/Spanish Origin
□ Other _____

Language: □ English □ Spanish □ Chinese □ Other _____

CONSENT TO TREAT

The primary treatment used by doctors of Chiropractic is the spinal adjustment. We will use primarily that procedure to treat you. The doctor may use his or her hands or a mechanical device upon your body in such a way as to move, or adjust, your joints. By signing below, you state that you are willing to undergo a chiropractic examination, x-rays of your spine (if indicated), and chiropractic treatment as may be outlined by the doctor after examination has been done.

Signature _____ Date _____

Consent to treat minor child _____ Date _____