

# Bearor Family Chiropractic

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## Personal Health History

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
Last Middle Initial First

Address: \_\_\_\_\_

Phone #'s: home \_\_\_\_\_ cell \_\_\_\_\_ work \_\_\_\_\_

Marital Status: Single Married Spouse Name: \_\_\_\_\_

# of Children: \_\_\_\_\_ Name(s)/Age(s): \_\_\_\_\_

Email address: \_\_\_\_\_ Would you like to receive our monthly email newsletter? Yes No

Reason for coming in: \_\_\_\_\_ Referred by: \_\_\_\_\_

Is condition: Job Related Auto Accident Fall Home Injury Other: \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

Is it reoccurring? Yes No Pains are: Sharp Dull Constant Intermittent

Rate your level of pain on a scale from 1 (minimal pain) to 10 (extreme pain) \_\_\_\_\_

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is condition worse during certain times of the day? Yes No Which times? \_\_\_\_\_

Is this condition interfering with: Work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Routine? \_\_\_\_\_ Other: \_\_\_\_\_

Is this condition getting progressively worse? Yes No

Have you been seen for this problem? Yes, by: Physician Chiropractor Physical Therapist  
No Other: \_\_\_\_\_

What did they do/recommend? \_\_\_\_\_

Have you had previous chiropractic care? Yes No When was last visit? \_\_\_\_\_ How often did you go? \_\_\_\_\_

What was the reason for your initial visit there? \_\_\_\_\_

How long were you receiving chiropractic adjustments? \_\_\_\_\_ Why did you discontinue care? \_\_\_\_\_

Are you pregnant? No Yes, due date: \_\_\_\_\_ Date of last menstrual cycle: \_\_\_\_\_

## Medications

Are you taking any medications? Yes No If yes, list and describe (how long, over the counter, prescription, etc.): \_\_\_\_\_

What side effects (if any) have you experienced from these drugs? \_\_\_\_\_

Have you had surgery? No Yes For what? \_\_\_\_\_ When? \_\_\_\_\_

## Accident History (such as auto/work/sport-related/falls/trauma/etc.) **Important Information...**

*All events which could have any impact upon the spine are of high significance to determine spinal history. Please fill out completely.*

Within the past year – when: \_\_\_\_\_ Describe: \_\_\_\_\_

Over a year ago – when: \_\_\_\_\_ Describe: \_\_\_\_\_

Childhood – when: \_\_\_\_\_ Describe: \_\_\_\_\_

Hospitalizations (other than above): \_\_\_\_\_

Birth Trauma? Yes No Explain (i.e. forceps, long labor/delivery, C-section, vacuum extraction, etc.) \_\_\_\_\_

Who is responsible your bill? Self Spouse Medicare Health Insurance Auto Insurance Other

If insurance, please present insurance card(s) and photo ID at Front Desk for copying.

Today's Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Last

Middle Initial

First

**Please check what applies to you...**

Do you purchase: health food products (organic products, etc.) Vitamins Probiotics  
Are you a member of a health club? Yes No Exercise: None Moderate Daily Heavy  
Do you: Smoke Drink alcohol – Drinks/week: \_\_\_\_\_ Drink caffeine/coffee – Cups/day: \_\_\_\_\_  
Consume artificial sweeteners Type: \_\_\_\_\_ Consume dairy products  
High stress level? Yes No If yes, reason: \_\_\_\_\_  
Hobbies: \_\_\_\_\_

**Please check any of the following that have given you difficulty in the last year:**

**General**

Headaches  
Shooting head pain  
Loss of memory  
Fatigue  
Depression  
Dizziness  
Thyroid trouble  
Chills  
Sweats  
Sleeping problems  
Seizures  
Fainting  
Irritability  
Nerves/nervousness  
Inner tension  
Weight gain  
Weight loss  
Twitching of face  
Facial pain  
Jaw pain (TMJ)  
Menstrual cramps/pain  
Menstrual irregularity  
Loss of balance  
Prostate trouble  
Cancer  
Shortness of breath  
Hernia  
Arthritis  
Diabetes  
Painful joints  
Swollen joints  
Ulcers

**Skin**

Bruise easily  
Hives  
Itching  
Change in moles  
Rash  
Sores that won't heal

**Gastrointestinal**

Bowel changes  
Intestinal gas  
Constipation  
Diarrhea  
Indigestion  
Nausea  
Stomach pain  
Stomach trouble  
Vomiting blood  
Gall bladder trouble

**Cardiovascular**

Anemia  
Chest pain  
Heart attacks  
Stroke  
Low blood pressure  
High blood pressure  
Poor circulation  
Irregular heart beat  
Rapid heart beat  
Swollen ankles

**Eye/Ear/Nose & Throat**

Loss of hearing  
Earache  
Sinus trouble  
Loss of smell  
Allergies  
Hay fever  
Asthma  
Loss of taste  
Inflammation of throat  
Persistent cough  
Ringing in ears

**Eye/Ear/Nose & Throat continued...**

Tonsillitis  
Blurred vision  
Sensitivity to light

**Neck**

Neck pain  
Grinding/popping in neck  
Neck stiffness  
Pinched nerve in neck  
Neck feels out of place  
Muscle spasms in neck

**Shoulders**

Shoulder/arm tightness  
Shoulder/arm pain  
Pain in shoulder joint  
Pain across shoulders  
Can't raise arms  
Tension in shoulders  
Pinched nerve in shoulders

**Mid Back**

Mid-back pain  
Spinal curvature  
Mid-back stiffness  
Pain between shoulder blades  
Pain from front to back  
Muscle spasms in mid-back

**Low Back**

Low-back pain  
Low-back stiffness  
Low-back weakness  
Low-back feels out of place  
Muscle spasms in low-back

**Arms & Hands**

Pins & needles in arms  
Pins & needles in hands  
Numbness in arms/hands  
Pain in upper arm  
Pain in elbow  
Pain in forearm  
Pain in hand  
Pain in fingers  
Weakness of hand  
Cold hands

**Hips/Legs & Feet**

Cold feet  
Pain in buttocks  
Pain in hip joint  
Pain down leg  
Pain in knee  
Pain in ankle  
Pain in foot  
Weakness of leg  
Weakness of knee  
Leg cramps  
Pins & needles in legs  
Numbness in legs/feet

**Urinary**

Bed wetting  
Blood in urine  
Frequent urination  
Lack of bladder control  
Painful urination  
Kidney trouble