

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