Focused Health
CHIROPRACTIC

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Patient Name:_____Today's Date:_____

Nickname:_____

Gender: _____ Date of Birth:_____ Age:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone: (H):_____ (W):_____ Cell:_____

Email Address:_____

Appointment Reminder Preference: Text_____ Email_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Marital Status: _____ Spouse/Partner_____ # Children_____

Primary Care Physician:_____Phone:_____

Whom may we thank for referring you to our practice?_____

HEALTH HISTORY

Main condition/symptom today:_____

How long have you had these conditions/symptoms?_____

Height: _____feet _____inches Weight:_____ Last known blood pressure: _____/_____ Hypertension: Yes___ No___

Surgeries:_____ Approx date:_____

Hospitalizations: _____ Approx date:_____

Major Illnesses:_____ Approx date:_____

Diabetes: Yes*_____ No_____ *If yes: Type I_____ Type II_____

Cancer: Yes_____ No_____ Type/Dates:_____

Patient Name:_____

Please circle any conditions or symptoms which are **currently or have previously** caused any problems.

General Symptoms
Headache
Recent fever
Dizziness
Loss of sleep
Nervousness/anxiety
Weight loss
Rashes/itching
Bruise easily
Asthma
Bowel/urinary problems
Prostate
Chest Pain
Autoimmune disease
Diabetes

Gynecological
Painful menstruation
Menopausal symptoms

Muscles & Joints
Neck pain
Back pain
Shoulder pain
Elbow pain
Wrist pain
Hand pain
Hip pain
Knee pain
Foot pain
Arthritis
Numbness/tingling
Swollen joints

Are you currently on Birth control? Yes / No
Births _____
C-Sections_____

Cardio Vascular
High blood pressure
Stroke
Poor circulation/Raynaud's
High cholesterol

Gastrointestinal
Indigestion/reflux
Nausea
Constipation
Diarrhea
Gall bladder trouble

EENT
Blurred vision
Frequent colds
Sinus infection
Difficulty swallowing

Have you ever had any fractures? Yes/No

Have you ever been in a car accident? Yes/No

Any other medical conditions not listed above:_____
_____

Are you currently taking any medications? (Include regularly used over-the-counter medications? Yes___ No_____

Medication Name	**For what condition?**
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any medication allergies? No_____ Yes_____ Explain:_____

Medication Name	**Reaction**	**Onset Date**	**Additional Comments**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family Medical History

Place a check for family history

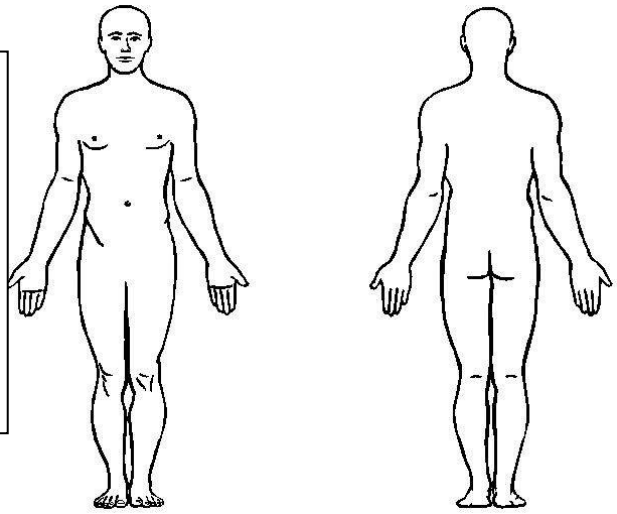
	Grand parents	Parents	Siblings
Cardiovascular			
Cancer			
Autoimmune disease			
Diabetes			
Other			

Patient Name:_____

Current Complaints

On the diagram, please indicate the location of pain and the symbol that best describes what you are currently experiencing:

SHARP/STABBING	++++
DULL/ACHEY	VVVV
PINS/NEEDLES	0000
NUMBNESS	////



Pain scale: please circle your pain level

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Do you have pain every day? Yes_____No_____ Does pain wake you at night? Yes_____ No_____

What increases your pain?_____

What decreases your pain?_____

I have no pain or symptoms. I understand that insurance does not cover wellness visits._____

Are your symptoms Worsening_____ Unchanged_____ Improved_____

Do you perform neck/back exercises Yes_____ No_____

Have you seen other doctors for this condition? If so, who?_____

Date of last physical exam:_____ Date of last spinal X-Ray /CT/MRI:_____

Social History check all that apply

Living with: spouse_____ alone_____ other_____

Smoking: never_____ former_____ every day_____ occasionally_____ Date started smoking_____

Caffeine: never_____ less than 3/day_____ 3-6 per day_____ more than 3-6 per day_____

Alcohol: never_____ casual_____ moderate_____ excessive_____ wine_____ beer_____

Recreational drug use: none_____ recreational_____ addiction_____

Exercise: never_____ daily_____ weekly_____ walk_____ run_____ swim_____

Lift weights w/resistance_____ yoga/pilates_____ other_____

Occupation:_____ or unemployed_____ student_____ retired_____

Employer:_____

Patient Name:_____ Date:_____

STarT Back: For these questions, please think about your pain over the **last few days**.

1. In the last **few days**, I have **dressed more slowly** than usual because of my pain.

Completely disagree										Strongly agree
0	1	2	3	4	5	6	7	8	9	10

2. In the last **few days**, I have only **walked short distances** because of my pain.

Completely disagree										Strongly agree
0	1	2	3	4	5	6	7	8	9	10

3. It's **really not safe** for a person with a condition like mine to be **physically active**.

Completely disagree										Strongly agree
0	1	2	3	4	5	6	7	8	9	10

4. **Worrying thoughts** have been going through my mind a lot of the time in the last few days.

Completely disagree										Strongly agree
0	1	2	3	4	5	6	7	8	9	10

5. I feel that **my pain is terrible** and that **it is never going to get any better**.

Completely disagree										Strongly agree
0	1	2	3	4	5	6	7	8	9	10

6. In general, in the last **few days**, I have **not enjoyed** all the things I used to enjoy.

Completely disagree										Strongly agree
0	1	2	3	4	5	6	7	8	9	10

7. Overall, how **bothersome** has your **pain** been in the **last few days**?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	1	2	3	4