

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: _____

Marital Status: _____ Spouse/Partner _____ # Children _____

Emergency Contact: _____ Phone: _____ Relationship: _____

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

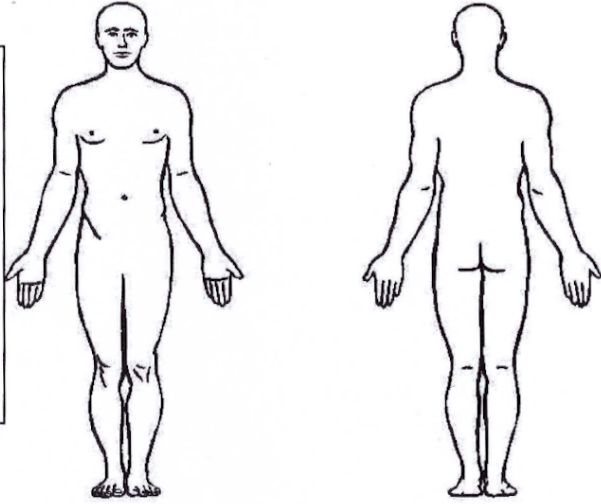
	Grand parents	Parents	Siblings
Cardiovascular			
Cancer			
Autoimmune disease			
Diabetes			
Other			

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

0

Slightly

1

Moderately

2

Very much

3

Extremely

4