

PATIENT HEALTH COMPLAINT FORM

Name _____ Today's Date _____

Address _____ City/State/Zip _____

Home Phone (____) _____ Work Phone (____) _____ S.S. # _____-____-____

Birthdate ____/____/____ Gender Male Female Height _____ Weight _____ # of Children _____

Occupation _____ Employer _____ Referred By _____

Who should we contact in case of emergency? _____ Phone (____) _____

Who is responsible for payment? Self Spouse Worker's Comp Medicaid
 Medicare Auto Insurance Personal Health Insurance Other _____

1. What is your chief complaint? _____

2. When did this complaint begin? (date) _____

3. What caused this problem? _____

4. Complaints/Disturbances: Come and Go Came on Gradually Came on Suddenly

5. Symptoms developed from: Work Related Injury Auto Accident Injury other than a Work or Auto Accident
 Other (explain) _____

6. If work related injury, has the injury been reported to your employer? Yes No

7. Symptoms are BETTER in: a.m. p.m.

8. Symptoms are WORSE in: a.m. p.m.

9. Symptoms have persisted for: Hours 1 Day Days Weeks Months Years

10. Have you seen any other doctors for this condition? If yes, please list name and address of doctor. Yes No

11. What activities make conditions WORSE? _____

12. What activities made conditions BETTER? _____

13. Have you ever had this condition/problem before? If yes, when? _____

14. Indicate ability to perform the following activities. (Use codes: U=Unable, P=Painful, D=Difficult, L=Limited, N=Normal)

_____ Coughing	_____ Lying on Back	_____ Sleeping	_____ Turning over in Bed
_____ Sneezing	_____ Lying Flat on Stomach	_____ Stooping	_____ Walking Short Distances
_____ Laughing	_____ Lying on Side with Knees Bent	_____ Gripping	_____ Standing More than One Hour
_____ Bending Forward	_____ Dressing Self	_____ Pushing	_____ Sitting at a Table
_____ Climbing	_____ Balancing	_____ Pulling	_____ Sexual Activity
_____ Kneeling	_____ _____	_____ Reaching	_____ _____

15. Have you ever been hospitalized and/or had surgery? Please explain. _____

16. Please list any medications you are presently taking. Include prescriptions and prescribing doctor, over the counter, oral contraceptives, vitamins & supplements, and the amount of each _____

17. When did you last have X-rays taken? _____

Patient's Signature _____ Date _____

Chiro-Health

CHIROPRACTIC CARE CENTERS, S.C.

FAMILY HISTORY:

	DIABETES	HEART	KIDNEY	CANCER	BACK	STROKE
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN:

Are you pregnant? Yes No Unsure/Possibly

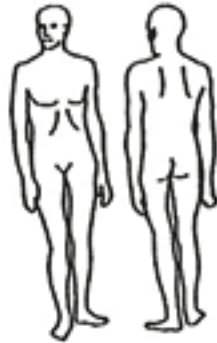
What was the first day of your last menstrual cycle? (date) _____

DISCOMFORT AREAS:

Shade and code areas to indicate location of pain or discomfort.

USE CODES:

- P=Pain
- S=Spasm
- N=Numbness
- T=Tenderness



CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | | | |
|--|---|--|---|--|---------------------------------------|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Malaria | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal Infection | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Eczema | <input type="checkbox"/> Polio | <input type="checkbox"/> _____ |

CHECK ANY OF THE FOLLOWING PROBLEMS YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

- | | | | | |
|---|--|---|--|--|
| MUSCLES & JOINTS
<input type="checkbox"/> Low Back Pain
<input type="checkbox"/> Pain Between Shoulders
<input type="checkbox"/> Neck Pain/Stiffness
<input type="checkbox"/> Arm/Elbow/Wrist Pain
<input type="checkbox"/> Walking Problems
<input type="checkbox"/> Difficulty Chewing
<input type="checkbox"/> Clicking Jaw
<input type="checkbox"/> Leg/Knee/Foot Pain
<input type="checkbox"/> Hip Pain
<input type="checkbox"/> Pain in Tailbone | EYE, EAR, NOSE & THROAT
<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Dental Problems
<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Earaches
<input type="checkbox"/> Hearing Difficulty
<input type="checkbox"/> Stuffed Nose
<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Nose Bleeds
<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Swollen Glands | HEART & LUNGS
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Asthma
<input type="checkbox"/> Short Breath
<input type="checkbox"/> Blood Pressure High
<input type="checkbox"/> Blood Pressure Low
<input type="checkbox"/> Irregular Heart Beat
<input type="checkbox"/> Heart Surgery
<input type="checkbox"/> Lung Congestion
<input type="checkbox"/> Coughing
<input type="checkbox"/> Spitting Blood
<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Ankle Swelling
<input type="checkbox"/> Bronchitis | STOMACH/INTESTINES
<input type="checkbox"/> Poor Appetite
<input type="checkbox"/> Excessive Appetite
<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Hemorrhoids/Piles
<input type="checkbox"/> Liver Trouble
<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Weight Trouble
<input type="checkbox"/> Stomach Cramps
<input type="checkbox"/> Stomach Pain
<input type="checkbox"/> Gas/Bloating
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Black/Bloody Stool
<input type="checkbox"/> Colitis
<input type="checkbox"/> Poor Digestion | MEN
<input type="checkbox"/> Prostate Pain
<input type="checkbox"/> Impotence
<input type="checkbox"/> Infertility |
| NERVOUS SYSTEM
<input type="checkbox"/> Nervousness
<input type="checkbox"/> Numbness
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Confusion
<input type="checkbox"/> Depression
<input type="checkbox"/> Fainting
<input type="checkbox"/> Convulsions
<input type="checkbox"/> Cold/Tingling Extremities | GENERAL PROBLEMS
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Frequent Colds
<input type="checkbox"/> Loss of Sleep
<input type="checkbox"/> Fever
<input type="checkbox"/> Headaches
<input type="checkbox"/> Weakness | KIDNEY/BLADDER
<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Excessive Urine
<input type="checkbox"/> Discolored Urine
<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Bad Urine Control | WOMEN
<input type="checkbox"/> Menses Irregular
<input type="checkbox"/> Menstrual Cramps
<input type="checkbox"/> Vaginal Pain
<input type="checkbox"/> Breast Lumps
<input type="checkbox"/> Pain During Sex
<input type="checkbox"/> Difficulty Getting Pregnant
<input type="checkbox"/> Miscarriage | HABITS
<input type="checkbox"/> Smoking - Packs/Day _____
<input type="checkbox"/> Alcohol - Drinks/Day _____
<input type="checkbox"/> Coffee - Cups/Day _____
<input type="checkbox"/> Soda - Cans/Day _____ |
| ALLERGIES
<input type="checkbox"/> Seasonal _____
<input type="checkbox"/> Allergic Reactions to: _____ | | | | |