

Thompson Chiropractic Clinic Patient History

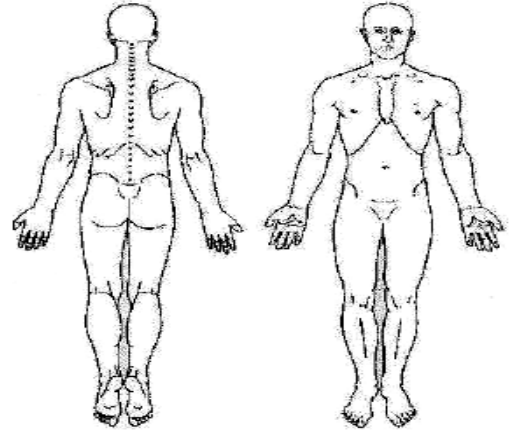
Name: _____ Date: _____
 Last First

Have you ever received Chiropractic Care? Yes No If yes, when? _____

What Spinal Correction programs were you given? _____

How did the post X-Rays look? _____

Please mark on the diagram below the area of discomfort. ↓



Chief Complaint / Concern: _____

Location of Complaint: _____

How and when did it begin? _____

Please circle the quality of the complaint / concern:

dull aching sharp shooting burning throbbing
 deep nagging other: _____

Does your complaint radiate to any areas of your body? Yes No

If Yes, where does it radiate? _____

Intensity / Severity of complaint / concern (Please Circle):

(No Pain / Discomfort) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain / Discomfort)

Frequency / Duration of complaint / pain during waking hours:

Intermittent: 0-25% Occasional: 26-50% Frequent: 51-75% Constant: 76-100%

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Daily Activities: How has your current condition affected your daily activities (check all that apply)?

- | | | | | |
|--------------------|------------------------------------|---|---|--|
| Standing | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Walking | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sitting | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Changing Positions | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Yardwork | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Exercise | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Bathing & Grooming | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Household Chores | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sleep | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sexual Activity | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Driving | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Computer Use | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Concentration | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |

Previous treatments or medications you have sought regarding your complaint / concern: _____

Past Health History:

Previous injuries or traumas (automobile accidents, broken bones, sprains/strains):

Date

Injury and Outcome

Allergies: _____

Current Medications (Prescription and Over-the-Counter):

Medication

Reason for taking

Surgeries:

Date

Type of Surgery and Outcome

Females: Pregnancy and Outcomes

Pregnancies / Date of Delivery

Outcome

Family Health History:

Health problems of parents, siblings, spouse, or children: _____

Social and Occupational History:

A.) Job description: _____

B.) Work schedule: _____

C.) Recreational Activities: _____

D.) Lifestyle (hobbies, level of exercise, alcohol, tobacco, drug use, diet): _____

On a scale of 1 to 10, 10 being the highest, what's your commitment to correcting your problem? _____

I hereby certify that my statements on this form are truthful and accurate to the best of my knowledge. I agree to allow Thompson Chiropractic Clinic to examine me for further evaluation.

Patient or Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____