POLAR FAMILY CHIROPRACTIC CENTER

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NAME: _____ DATE: _____ DOB: _____ AGE _____

PERSONAL HISTORY

What is the reason for your visit today? _____

Date you first noticed this problem/date of injury: _____

Have you experienced same or similar problems in the past? ( ) yes ( ) no

If yes, please explain: _____

How is your condition now compared to initially? ( ) worse ( ) same ( ) better

If pain is a component of your current complaint, please complete the following questions

Please circle the number corresponding to how bad your pain is:

NO PAIN 1 2 3 4 5 6 7 8 9 10 SEVERE

Where is the pain most intense? _____

The pain is: ( ) constant ( ) intermittent

Does the pain travel or radiate to any other part of your body? ( ) yes ( ) no

If yes, please explain: _____

How long does the pain usually last? _____

Please mark any of the following that describe the pain you are experiencing:

( ) mild	( ) moderate	( ) considerable	( ) severe	( ) dull
( ) burning	( ) throbbing	( ) stabbing	( ) shock-like	( ) sharp

What part of the day is your pain most severe? _____

Does the pain ever awaken you at night? ( ) yes ( ) no

In what position are you most comfortable? _____

What positions or activities aggravate your condition? _____

Is the condition interfering with your work or duties at home? ( ) yes ( ) no

If yes, in what way? _____

What self treatments have you used? _____

How effective have these self treatments been? _____

Does anyone in your family suffer from the same or similar problem? ( ) yes ( ) no

Have you ever seen a doctor of chiropractic in the past? Y N If so, what for?

Have you seen any other health care providers for this condition? Y N If yes, please give name and address:

Please list any medications you are currently taking and what they are for:

1.
2.
3.
4.

Please list any herbs or nutritional supplements you are currently taking and what they are for:

1.
2.
3.

Please indicate the amount you use each day of the following products:

_____cups of coffee per day _____ ounces/cans of soft drinks per day

_____ cans/glasses of beer, wine, other alcohol per day/week.

Do you or have you ever used tobacco products (cigarettes, chewing tobacco)? Y N

If yes, please indicate how much and how long you used/have used:

List recreational activities:

Please circle the amount of physical activity/exercise you do: None Mild Moderate Strenuous

List any allergies:

Indicate if you or someone in your family has a history of the following:

	SELF	FAMILY MEMBER
High blood pressure		
Heart disease		
Cancer		
Diabetes		
Bleeding disorder		
Depression		

Please describe any accidents or falls you have experienced as a child or an adult

Please list any fractures or dislocations you have experienced

Please list any surgeries and/or hospitalizations and their approximate date.

1.
2.
3.
4.

Please CIRCLE any of the following diseases/conditions you currently have or had in the past.

alcoholism anemia appendicitis arthritis cancer
diabetes epilepsy heart disease mental disorder pneumonia
polio tuberculosis hepatitis

GENERAL SYMPTOMS

headache (frequency _____) fever chills sweats
loss of weight fainting convulsions loss of sleep fatigue
numbness in arms numbness in hands numbness in legs numbness in feet nervousness
allergy wheezing dizziness

RESPIRATORY SYMPTOMS

chronic cough spitting up phlegm spitting up blood chest pain difficulty breathing

CARDIOVASCULAR SYMPTOMS

rapid heart beat slow heart beat high blood pressure low blood pressure pain over heart
previous stroke hardening of arteries swelling of ankles poor circulation paralytic stroke

MUSCLE AND JOINT SYMPTOMS

stiff neck backache swollen joints hernia pain between shoulders
tremors painful tailbone foot trouble spinal curvature faulty posture

GASTROINTESTINAL SYMPTOMS

poor appetite difficult digestion excessive hunger belching or gas nausea
vomiting vomiting of blood constipation diarrhea colon trouble
hemorrhoids (piles) liver trouble gall stones

GENITOURINARY SYMPTOMS

frequent urination painful urination blood in urine pus in urine bed wetting
prostate trouble inability to control urine kidney infection or stones

EYES, EARS, NOSE AND THROAT SYMPTOMS

eye pain deafness earaches ear noises ear discharge
nose bleeds nasal obstruction sore throat hoarseness asthma
frequent colds tonsillitis sinus infection nasal drainage enlarged glands
hayfever

FOR WOMEN ONLY

painful menstruation excessive flow hot flashes irregular cycle cramps
backache previous miscarriage lumps in breast vaginal discharge menopausal symptoms

Are you pregnant right now? ( ) Yes ( ) No First day of last menstrual period? _____

Is there any other information you feel may be helpful in the evaluation of your condition? _____

_____

_____

_____

_____