Clock Tower Chiropractic and Massage

History of Condition

PATIENT NAME ____ DATE ______________________

Note: This form is designed to help locate areas that need further medical investigation. The doctor will ask in-depth questions later if necessary. You are not required to answer any questions that you feel are too personal. All answers are confidential.

Current problem questions:

Where is your problem? ____

____Onset Date__________________

How did it start? Circle

Automobile	Sports	Slip and fall	Excessive standing or walking
Prolong driving	Lifting	Occupational work	

Other____

Type of pain:

Dull	Sharp	Throbbing	Burning	Deep	Achy
Tingling	Stabbing	Cramping	Numbness	Radiating	

Other____

Aggravating Factors:

Sitting	Standing	Walking	Bending	Stooping	Lifting
Sleeping	Sneezing	Coughing	Straining	Reaching	Twisting
Looking up	Looking down	Movement	Rest	Lying Supine	Driving
Typing	Scooping	House chores	Exercise	Lying prone	Stair stepping

Other____

Relief Factors:

Sitting	Standing	Lying	Knees bent	Support
No movement	Movement	Heat	Ice	Analgesic topical
Anti-inflammatory	Medication	Rest	Stretching/Exercise	Adjustment

Other____

Mark all areas you have pain or other symptoms

Mark how you feel today. Note if more than one area.

/____/

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable

How much has your condition interfered with activities/chores?

/____/

0 1 2 3 4 5 6 7 8 9 10

No interference Unable to do

How does it interference with your work, family life, hobbies, and sports?

____

How have you been treating the condition? ____

Have you seen anyone else about this condition? ☐ Yes ☐ No Who? ______________________

Other areas of complaint: ____

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Health History

ALLERGIES: ☐ Yes ☐ No

Allergies to: ________________________________ Reaction: ______________________________

Medication Allergies: ☐ Yes ☐ No

Allergies to: ________________________________ Reaction: ______________________________

DO YOU HAVE ANY FAMILY HISTORY OF?

- -cancer ☐ Yes ☐ No
- -diabetes ☐ Yes ☐ No
- -high blood pressure ☐ Yes ☐ No
- -heart disease/Stroke ☐ Yes ☐ No
- -back problems ☐ Yes ☐ No

HOSPITALIZATION:

List other hospitalizations, reasons and date

____

____

General physician's name ____

Date of last visit with general physician ______________________________________

Name of any specialists ____

List any current confirmed diagnosis ____

____

Have you ever consulted a Chiropractor before?_________________________________

Chiropractor's name ___________________________ Date of last visit _________________

Reason for discontinuing care ____

Were you satisfied with the treatment? ☐ Yes ☐ No

INJECTIONS: **(**For example Cortisone) ☐ Yes ☐ No

Date: __________________ Type: ____________________________ Site: _____________________

LABS, MRI, or X-RAYS:

Have you had a MRI or X-rays? ☐ Yes ☐ No Date: ______________

Area:_________________________________ Where were they taken?_______________________

Any relevant lab work? _______________________________ Date of Lab work? ______________

MEDICATIONS: List any medication you are currently taking, including birth control pills

Medication	Form	Quantity	Frequency	Start Date	Physician

NUTRITIONAL SUPPLEMENTS:

Do you take vitamins or minerals ☐ Yes ☐ No List supplements _________________________

____

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REVIEW OF SYSTEMS:

DO YOU HAVE ANY HISTORY OF?

EYES:

-trauma	☐ Yes	☐ No
-infection	☐ Yes	☐ No
-double vision	☐ Yes	☐ No
-blurring	☐ Yes	☐ No

MOUTH AND THROAT:

-mouth sores	☐ Yes	☐ No
-difficulty swallowing	☐ Yes	☐ No
-jaw pain	☐ Yes	☐ No
-clicking or dislocation	☐ Yes	☐ No

HEADACHES: ☐ Yes ☐ No If "yes" how often ________________________________

Pain level from 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (0 = no pain to 10 =extreme) __________

OSTEOPEROSIS: ☐ Yes ☐ No Level and date ____________________________________

NOSE:

-allergies	☐ Yes	☐ No
-sinus pain	☐ Yes	☐ No

EARS:

-earaches	☐ Yes	☐ No
-ringing	☐ Yes	☐ No
-unsteadiness	☐ Yes	☐ No

RESPIRATORY

-Asthma	☐ Yes	☐ No
-Pneumonia	☐ Yes	☐ No
-Emphysema	☐ Yes	☐ No
-shortness of breath	☐ Yes	☐ No
-difficulty breathing	☐ Yes	☐ No

CARDIOVASCULAR:

-heart problems	☐ Yes	☐ No
-Phlebitis	☐ Yes	☐ No
-circulation problems	☐ Yes	☐ No
-chest pain	☐ Yes	☐ No
-fast heart beat	☐ Yes	☐ No
-swelling of the feet	☐ Yes	☐ No
-stroke	☐ Yes	☐ No
-low/high blood pressure	☐ Yes	☐ No
-rheumatic fever	☐ Yes	☐ No
-easy bruising	☐ Yes	☐ No
-irregular heart beat	☐ Yes	☐ No

MUSCULOSKELETAL:

-Do you experience joint pain or swelling?	☐ Yes	☐ No
-Are you aware of any birth defects?	☐ Yes	☐ No
-Any muscle weakness?	☐ Yes	☐ No

-List accidents, major falls or injuries ____

____

GASTROINTESTINAL

-Do you have stomach or abdominal pain	☐ Yes	☐ No
-distention	☐ Yes	☐ No
-nausea or vomiting	☐ Yes	☐ No
-constipation	☐ Yes	☐ No
-change in bowel habits lately	☐ Yes	☐ No
-diarrhea	☐ Yes	☐ No
-heartburn	☐ Yes	☐ No

GENITOURINARY

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-pain or discomfort when urinating ☐ Yes ☐ No
-difficulty starting or stopping a stream ☐ Yes ☐ No

-kidney stones	☐ Yes	☐ No	-herpes	☐ Yes	☐ No
-blood or discharge in urine	☐ Yes	☐ No	-syphilis	☐ Yes	☐ No
-venereal disease	☐ Yes	☐ No	-A.I.D.S.	☐ Yes	☐ No
-bladder or kidney disease	☐ Yes	☐ No	-urinary frequency	☐ Yes	☐ No

MEN

-prostate problems ☐ Yes ☐ No

WOMEN

-periods regular ☐ Yes ☐ No date of last period ______________________________
-menopause ☐ Yes ☐ No when begun ____________________________________
-Are you pregnant? ☐ Yes ☐ No
Number of pregnancies ____________________ viable births ______________________________

LIFESYLE:

-Do you take posture breaks during the day? ☐ Yes ☐ No
-How much time is spent sitting? ____
-Do you drive a lot? ☐ Yes ☐ No
-Do you wear: ☐ ***Heel lifts*** ☐ ***Sole lifts*** ☐ ***Inner soles*** ☐***Arch supports*** ☐***Orthotics***
-Which type of bedding do you use? ☐ ***Soft*** ☐ ***Firm*** ☐ ***Bed board*** ☐ ***Water bed***
-Is it comfortable? ☐ Yes ☐ No
-How many pillows do you use? ____

SMOKING HX:

-Do you smoke? ☐ Yes ☐ No -If so, how much per day? ________________
-Did you previously smoke? ☐ Yes ☐ No -If so, how much? ________________________
-Level of interest in quitting ☐ Yes ☐ No
none - 0 1 2 3 4 5 6 7 8 9 10- want help

SOCIAL HX:

-Alcohol consumption per day/week/month____
-Coffee consumption per day/week/month____
-Soda pop consumption: per day/week/month____
-Water consumption: per day/week/month____
-Sleep Amount Hours per night ____
-Pain Reliever Frequency ____
-Recreation Drug use____
-Healthy Eating, rank: poor- 0 1 2 3 4 5 6 7 8 9 10 -excellent
-Exercise number of days per week/month____
-Type of exercise? ____

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Is there anything causing excessive stress and tension? ☐ Yes ☐ No

Physical Stress Ranking	none- 0	1	2	3	4	5	6	7	8	9	10 -extreme
Emotional Stress Ranking	none- 0	1	2	3	4	5	6	7	8	9	10 -extreme

What is your present occupation? ______________________________
Do any of your recreational activities contribute in a good or bad way? ☐ Yes ☐ No
Why? ______________________________
____

SURGERIES:
List major surgeries and date ______________________________
____

VITALS:
Height:______________________________
Weight:______________________________
Have you had any significant change in diet or lifestyle lately? ☐ Yes ☐ No
Are you/should you be on a special diet? ☐ Yes ☐ No
Describe______________________________
Blood Pressure ________________ Date of Last Blood Pressure Check____________

Briefly list your main health problems: ______________________________

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No
If yes, describe: ______________________________
____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No
If yes, what kind? ❑ Type I ❑ Type II
Was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure
Other comments regarding Diabetes: ______________________________

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

Height: _____inches	Weight: _____ pounds	BP: __ / ____

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