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: _____

Dr. Sarah Colby, Chiropractic Physician
9375 SW Commerce Circle, Suite A1
Wilsonville, Oregon 97070
503-685-9841
www.wilsonvillechiropractor.com

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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	-high blood pressure	☐ Yes	☐ No
-diabetes	☐ 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 low back spine in the past 28 days? ❑ Yes ❑ No

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

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