

CONFIDENTIAL HEALTH HISTORY

Today's Date: _____ How did you hear about South Lyon Chiropractic? _____

Have you consulted a chiropractor before? No Yes Whom? _____ When? _____ Why? _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____
Street, Apt # City, State Zip Code

Cell Phone: __ (____) _____ Home Phone: __ (____) _____

Email Address: _____ Age: _____ Birth date: _____

Insurance Company: _____

Marital Status: Single Currently in a Relationship Married Divorced Widowed Separated

Number of Children: _____ Children's Name & Ages: _____

Emergency Contact Name: _____ Relationship: _____ Phone #: _____

Your Occupation: _____ Your Employer: _____

PAST MEDICAL HISTORY

Is your visit due to an **accident, injury or trauma**? No Yes - If so, was it: Auto Work - Please Explain: _____

List any **accidents, injuries or traumas** you have experienced: _____

List any **surgeries** or major **illnesses**: _____

List any major **allergies**: _____

Have you ever been to an **emergency room**? No Yes - explain: _____

Have you ever been **admitted** to a **hospital**? No Yes - explain: _____

What **medications** and/or **vitamins** are you taking? _____

Do you **carry medication** in case of an emergency? No Yes - explain: _____

Has a physician treated you for any **health condition** in the past year? No Yes - Please explain: _____

Diagnostic Imaging: X-Ray MRI CAT Scan When? _____ Where? _____

Do you have any **implanted medical devices** or **imbedded foreign objects**? No Yes - _____

Have you ever been fitted for a special **brace**, worn a **brace** or worn a **cast**? No Yes - _____

When was your **last physical exam**? _____ - Normal? No Yes **Primary Doctor Name & Location:** _____

FEMALES: Do you see a gynecologist regularly? No Yes **MALES:** Do you have a Prostate Exam regularly? No Yes

Are you in good **overall health**? _____ **High Blood Pressure?** No Yes **Last Check?** _____

FAMILY HISTORY

Any major **illnesses** in your **family**? No Yes: Heart Disease Stroke Diabetes Cancer Other: _____

SOCIAL HISTORY

Do you have any special **dietary** habits? No Yes: _____ Exercise? _____

Do you **smoke**? YES NO Do you **drink**? Yes No What are your **hobbies**? _____

What is the major **stressor** in your life _____ Hours of **sleep** per night: _____ **Sleeping position?** _____

CURRENT CONDITION

1. The **symptom(s)** that have prompted me to seek care today include: _____

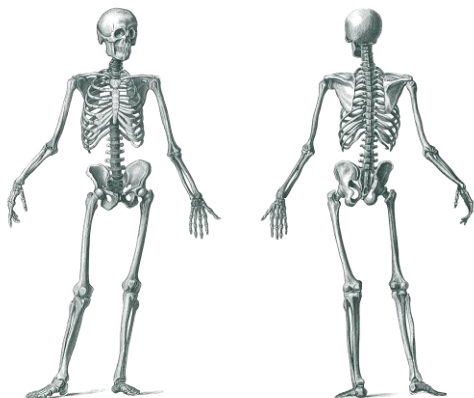
2. **Onset** (When did you first notice your current symptom(s)): _____

3. **Intensity:** (How extreme are your current symptoms?) 10
Absent Uncomfortable Agonizing

4. **Duration and Timing:** (When did it start & how often do you feel it?) Constant Comes & Goes How Often? _____

5. **Feels?** Numbness Tingling Stiffness Dull Aching Cramps Nagging Sharp Burning Shooting
 Throbbing Stabbing Other: _____

6. **Location** (Where does it hurt?)



7. **Radiation** (What areas does the pain go?): _____

8. What tends to **worsen** this problem? _____

9. What tends to **lessen** the problem? _____

10. **Prior interventions** (what have you done to try and relieve the symptoms)

Prescription Medication Surgery Ice
 Over-the-Counter Drugs Acupuncture Heat
 Homeopathic Remedies Chiropractic Physical Therapy
 Massage Other: _____

11. Additional **Questions** about your condition.

- Is your pain/problem worse at night? _____ No Yes N/A
- Does your pain/problem improve with bed rest? _____ No Yes N/A
- Does the current pain/problem awaken you after falling asleep? _____ No Yes N/A
- Is the following statement **true** regarding your pain/problem:
 - "there is no position that relieves my pain/problem" _____ No Yes N/A
- Do you notice any other symptoms, areas of weakness or sensations? -- No Yes N/A

Acknowledgements - Please read the statement and sign your agreement.
To the best of my ability, the information I have supplied is complete and truthful.
I have not misrepresented the presence, severity, or cause of my health concern.

Print Name

Signature

Date