davis square chiropractic

Date _____

Personal Health History Form

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

Name _____ Preferred Nickname _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Marital status? _____

Cell Phone _____ E-mail Address _____

Gender: _____ Pronouns: _____ Birth Date _____ Age _____

Employer/School _____ Occupation _____

Employment Address _____

In Case of Emergency Contact _____ Phone _____

Referred by _____ Have you ever been treated by a chiropractor before? ☐ Yes ☐ No
If so, when? _____

How would you describe your chief complaint at this time?

_____

_____

When did it start (include month & year, day if known)? _____

The pain is: ☐ Intermittent ☐ Constant

Rate of severity (1=Mild, 10=Unbearable)? 0 1 2 3 4 5 6 7 8 9 10

Does the pain travel? If so, where? _____

What makes the pain worse? _____

What makes the pain better? _____

How would you describe your pain? ☐ Achy ☐ Dull ☐ Tight ☐ Stiff ☐ Cramp ☐ Numb ☐ Tingling
☐ Sharp ☐ Shooting ☐ Burning ☐ Stabbing ☐ Throbbing ☐ Other_____

At what time of the day or week is your pain worse? _____

Have you had this problem in the past? ☐ Yes ☐ No If so, when & how often? _____

Have you seen anyone else for this condition? ☐ Yes ☐ No If so, who? _____

Which aspect(s) of your life is this symptom or condition interfering with?

☐ Work ☐ Exercise ☐ Recreation ☐ Sleep ☐ Relationships ☐ Self-Care
☐ Energy levels ☐ Productivity ☐ Attitude ☐ Patience ☐ Creativity ☐ Other_____

Is this a result of a Motor Vehicle Accident? □Yes □No *If so, have you filed a legal suit?* □Yes □ No

Is this a result of a work-related injury? □Yes □No *If so, have you filed a worker's comp claim?* □Yes □ No

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Please list any accidents, injuries, surgeries, and hospitalizations you have had.

_____ Date or Age _____

_____ Date or Age _____

_____ Date or Age _____

Do you or other family members have a history of any of the following?

Arthritis	□ Self	□ Family member _____
Asthma	□ Self	□ Family member _____
Cancer	□ Self	□ Family member _____
Diabetes	□ Self	□ Family member _____
Digestive Issues	□ Self	□ Family member _____
Dizziness	□ Self	□ Family member _____
Epilepsy	□ Self	□ Family member _____
Headaches	□ Self	□ Family member _____
Heartburn	□ Self	□ Family member _____
Heart Disease	□ Self	□ Family member _____
Hypertension	□ Self	□ Family member _____
Hypoglycemia	□ Self	□ Family member _____
Kidney Disease	□ Self	□ Family member _____
Mental Illness	□ Self	□ Family member _____
Migraines	□ Self	□ Family member _____
Neurologic Issues	□ Self	□ Family member _____
Osteoporosis	□ Self	□ Family member _____
Reproductive Issues	□ Self	□ Family member _____
Scoliosis	□ Self	□ Family member _____
Stroke	□ Self	□ Family member _____
Thyroid Issues	□ Self	□ Family member _____

How many times per week do you engage in physical activity that is sufficiently prolonged and intense to cause sweating and a raised heart rate?_____

Please rate your level of fitness (0 = very poor, 5 = average, 10 = excellent) _____

Do you smoke tobacco? _____ If so, how much per day? _____

What medications, vitamins, supplements, and/or herbs do you take?

Name	**Reason**
_____	_____
_____	_____
_____	_____
_____	_____

Please list any allergies that you have.

_____