Date_____

Community Chiropractic Center

Personal History Update

Patient Name:_____ Date of Birth:____/____/____ Gender: ☐M ☐ F

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Business:_____

Your Occupation:_____ Company Name:_____

E-mail: _____

Spouse's Name:_____ Spouse's Date of Birth:_____/_____/_____

INSURANCE: Subscriber Name: _____ Health Plan:_____

Subscriber ID #: _____ Group #:_____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-back Pain ☐ Low Back Pain

☐ Other _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began:_____

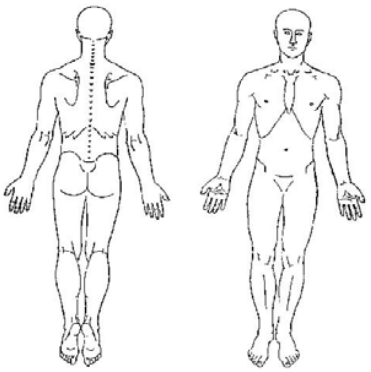
How Problem Began:_____

Current complaint:

0 1 2 3 4 5 6 7 8 9 10

No Pain **Unbearable Pain**

Mark an X on the body diagram where you have pain or other symptoms



How often are your symptoms present?

(Intermittent) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g. work, household chores, etc.)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Have you had spinal X-Rays, MRI, CT Scan for your area(s) of complaint? ☐ No ☐ Yes

Date(s) taken: _____ What areas were taken? _____

Please check all of the following that apply to you:

☐ Recent Fever ☐ Diabetes ☐ Stroke (date): _____ ☐ Marked Morning Pain/Stiffness

☐ Osteoporosis ☐ Dizziness/Fainting ☐ Numbness in Groin/Buttocks ☐ Currently Pregnant, # weeks: _____

☐ Arthritis ☐ Epilepsy/ Seizures ☐ Pain Unrelieved by Position or Rest

☐ Prostate Problems ☐ Pain at Night ☐ Corticosteroid Use (cortisone, prednisone, etc.)

☐ Urinary Problems ☐ Menstrual Problems ☐ Surgeries: _____

☐ High Blood Pressure ☐ Taking Birth Control ☐ Cancer/Tumor:: _____

☐ Visual Disturbances ☐ Weight Loss/Gain ☐ Medications: _____

☐ Other Health Problems: _____

In order for us to help you achieve your health goals, please let us know if you are taking any vitamins or supplements for:

☐ Arthritis ☐ Energy ☐ Bone Loss ☐ Cholesterol

☐ Body Aches ☐ Muscle Cramps ☐ Other: _____

I understand that I am responsible for payment of services at the time of care unless other financial arrangements have been made during my visit.

Patient Signature _____ **Date** _____