CONFIDENTIAL PATIENT HISTORY

Date: _____

Last _____ First _____ Middle Initial _____ Birth Date _____ Age _____

Address _____ City _____ ST_____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Email _____

Occupation _____ Employer _____

Spouse's Name _____ D.O.B _____ Spouse Ph _____ Employer _____

Children's Name & Ages _____

How did you hear about our office? _____

Have you ever been treated by a chiropractor? _____

Who is your primary care physician? _____

Emergency Contact_____ Phone_____ Relationship_____

WHAT BRINGS YOU TO OUR OFFICE? **Please provide as much detail as possible.**

PRIMARY COMPLAINT: _____

Date when symptom started _____ How Did it begin: _____

How often do you experience these symptoms? ☐ Constant 100% ☐ Frequent 75% ☐ Intermittent 50% ☐ Occasional 25% ☐ Rare10%

Have you ever experienced the same or similar symptoms? ☐ yes ☐ no When? _____

Have you been to another doctor for this problem? ☐ yes ☐ no Who/Where? _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Other Do you have Numbness or Tingling? ☐ yes ☐ no

Where? _____

Does the Pain Radiate into: ☐ Arm ☐ Hand ☐ Leg ☐ Foot ☐ Other _____ ☐ Does not radiate

What makes the symptoms increase? _____ What relieves the symptoms? _____

Do you have a pacemaker or implantable cardioverter-defibrillator (ICD) _____

SECONDARY COMPLAINT: _____

Date when symptom first appeared _____ How Did it begin: _____

How often do you experience these symptoms? ☐ Constant 100% ☐ Frequent 75% ☐ Intermittent 50% ☐ Occasional 25% ☐ Rare10%

Have you ever experienced the same or similar symptoms? ☐ yes ☐ no When? _____

Have you been to another doctor for this problem? ☐ yes ☐ no Who/Where? _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Other Do you have Numbness or Tingling? ☐ yes ☐ no

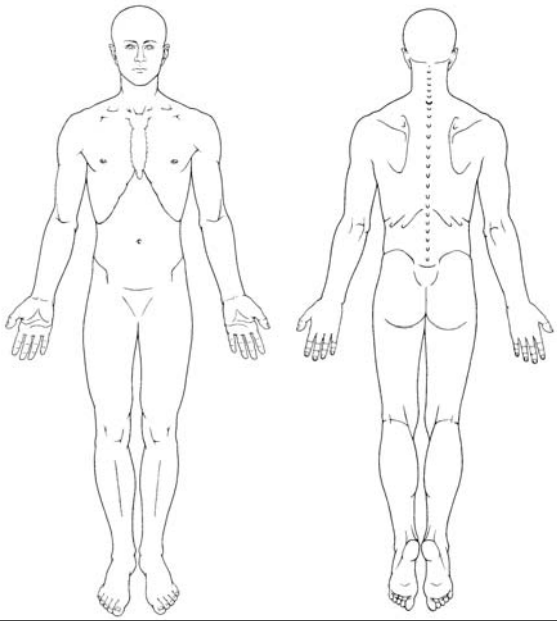
Where? _____

Does the Pain Radiate into: ☐ Arm ☐ Hand ☐ Leg ☐ Foot ☐ Other _____ ☐ Does not radiate

What makes the symptoms increase? _____ What relieves the symptoms? _____

Please mark off all areas of complaint on the diagrams with the following indicators:

AAA=ache
DDD=dull
NNN = numbness
TTT= tingling
BBB= burning
SSS=sharp/stabbing
XXX = other



Please list any medications or vitamins you are currently taking (including dosage).

_____
_____
_____
_____
_____
_____
_____

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme)

0 ◊◊◊ 1 ◊◊◊ 2 ◊◊◊ 3 ◊◊◊ 4 ◊◊◊ 5 ◊◊◊ 6 ◊◊◊ 7 ◊◊◊ 8 ◊◊◊ 9 ◊◊◊ 10

Please check if you have had any of the following:

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Arthritis	☐ Disc Degeneration	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Fibromyalgia	☐ Asthma	☐ Numbness/Tingling
☐ Allergies	☐ High Cholesterol	☐ Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Glaucoma	☐ Diabetes	☐ High Blood Pressure
☐ Cancer	☐ Nervousness	☐ AIDS/HIV	☐ Osteoporosis	☐ Heart Disease/Problems
☐ Paralysis	☐ Parkinson's Disease	☐ Kidney Disease	☐ PMS/Cramps	☐ Prostate Problems
☐ Rheumatoid Arthritis	☐ Sciatica	☐ Sinus Pain	☐ Pacemaker	☐ Stroke
☐ Thyroid Problems	☐ Tumors/Growths	☐ Urinary Problems	☐ Vascular Disease	☐ Vision Problems
☐ Other:				

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Mount Pleasant Spine Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Mount Pleasant Spine Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____