YEAGER CHIROPRACTIC AND WELLNESS CENTER
PERSONAL HISTORY FORM

Chart No.: _____

Name: _____ Age: _____ Date: _____

Primary Care Physician/Clinic Name: _____ Phone #: _____

Referring Physician/Clinic Name: _____ Phone#: _____

Past Chiropractic Physician/Clinic Name: _____ Phone#: _____

May we contact any of your physicians for coordination of care if needed? ☐ Yes ☐ No

CURRENT CHIEF COMPLAINT:

Reason for your visit/Location of symptoms: _____

When did your symptoms begin? _____ How did your symptoms start? _____

Have you ever had the above symptoms or a similar problem before? ☐ Yes ☐ No

What treatment have you already received for the condition above? ☐ Medication ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Care ☐ Massage ☐ Acupuncture ☐ None ☐ Other _____

If you had any treatments above, how did you respond? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Do you <u>currently</u> have any of the following symptoms? Check all that apply.

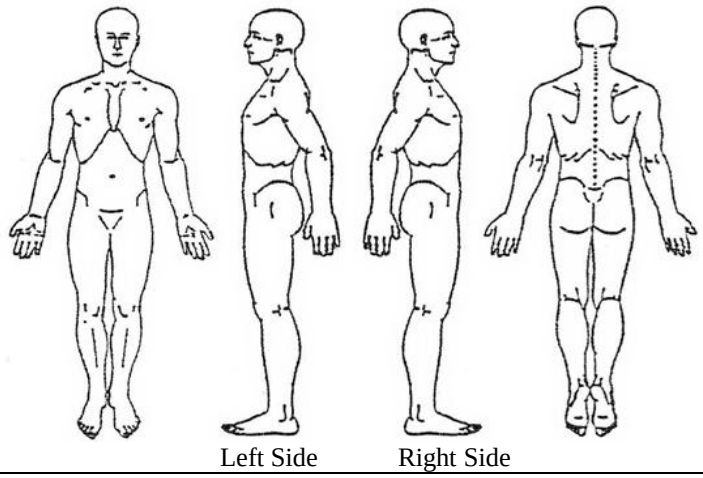
☐ Fever	☐ Headaches	☐ Ringing in the ears	☐ Shoulder blade pain
☐ Dizziness	☐ Migraines	☐ Difficulty hearing	☐ Shoulder pain
☐ Fainting	☐ Sinus issues	☐ Difficulty swallowing	☐ Arm/hand pain
☐ Loss of weight	☐ Blurry vision	☐ Difficulty breathing	☐ Low back pain
☐ Muscle weakness	☐ Double vision	☐ Pain w breathing/cough/sneeze	☐ Hip pain
☐ Joint pain/swelling	☐ Loss of sleep	☐ Loss of bowel or bladder control	☐ Leg/foot pain
☐ Chest pain	☐ Blood in urine	☐ Jaw/TMJ pain	☐ Facial numbness/tingling
☐ Constipation	☐ Blood in stool	☐ Neck pain	☐ Upper extremity numbness/tingling
☐ Diarrhea	☐ Abdominal pain	☐ Mid-back pain	☐ Lower extremity numbness/tingling

Mark the areas on the **picture to the right** where you feel your symptoms with the appropriate symbol(s) below. If your pain/sensation travels a distance, then use an arrow that travels the length and direction of the radiation.

Achy >>> Throbbing +++

Burning **XXX** Numbness **000**

Stabbing / / / Pins/needles ***



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In the past twelve months, have you had imaging studies or other tests for your chief complaint? ☐ Yes ☐ No

If yes, please check below and include the date of the test/imaging and any results you can recall (example: normal, arthritis, disc bulge, etc.).

Test/Images	Date	Results	Test/Images	Date	Results
☐ EMG/NCS	_____	_____	☐ Bloodwork	_____	_____
☐ MRI	_____	_____	☐ CT	_____	_____
☐ X-rays	_____	_____	☐ Myelogram	_____	_____
☐ Bone Scan	_____	_____	☐ Discogram	_____	_____

CURRENT MEDICAL PROBLEMS (Check all that apply):

☐ AIDS/HIV	☐ Diabetes (Type I or II)	☐ Irregular Heartbeat	☐ Seizures
☐ Arthritis/Gout	☐ Depression	☐ Liver or Kidney Problems	☐ Stroke
☐ Asthma	☐ Emphysema / COPD	☐ Neuropathy	☐ Thyroid Disease
☐ Bleeding Condition	☐ Glaucoma	☐ Osteoporosis	☐ Ulcers or Reflux
☐ Blood Clots / DVT	☐ Heart Disease or Attack	☐ Pacemaker or heart valve	☐ Other_____
☐ Cancer (Type/Location)	☐ High Blood pressure	☐ Pancreatitis	_____

MEDICAL HISTORY

List current medications and supplements and any allergies you may have.

Current Medications	Current Vitamins/Herbs/Supplements	Allergies
1._____	1._____	Medications: _____
2._____	2._____	_____
3._____	3._____	Foods: _____
4._____	4._____	Environmental: _____

Have you had any serious injuries, surgeries or serious illnesses? ☐ Yes ☐ No If yes, fill in the lists below & include dates.

Falls/ Accidents	Broken Bones	Surgeries
1._____	1._____	1._____
2._____	2._____	2._____
3._____	3._____	3._____
4._____	4._____	4._____

Serious Illness and Hospitalizations

1._____

2._____

SOCIAL HISTORY

Exercise	**Work Activity**	**Habits**
☐ None	☐ Sitting	Coffee/Caffeine Drinks ☐ None ☐ Number of cups per day_____
☐ Light	☐ Standing	Alcohol use: ☐ None ☐ Number of drinks per week _____
☐ Moderate	☐ Light Labor	Tobacco use: ☐ Smoke ____ packs/day ____Years smoked ☐ Chewing tobacco ☐ Cigars
☐ Heavy	☐ Heavy Labor	Did you ever smoke? ☐ Yes ☐ No If yes, when did you quit? _____

High Stress Level ☐ Yes ☐ No If yes, why? _____
Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed
Are you pregnant? ☐ Yes ☐ No Is it possible that you could be pregnant? _____
How many children do you have? _____
Height _____ Weight _____ Weight one year ago _____ Max weight _____

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PAST MEDICAL HISTORY

Have you ever had any of the following? (Check all boxes that apply)

☐ Alcoholism	☐ Chemical Dependency	☐ Hepatitis	☐ Multiple Sclerosis	☐ Scarlet Fever
☐ Allergy Shots		☐ Hernia	☐ Mumps	☐ Stroke
☐ Anemia	☐ Chicken Pox	☐ Herniated Disc	☐ Parkinson's Disease	☐ Thyroid Problems
☐ Anorexia	☐ Epilepsy	☐ Herpes	☐ Pneumonia	☐ Tonsillitis
☐ Appendicitis	☐ Emphysema	☐ High Cholesterol	☐ Polio	☐ Tremors
☐ Breast Lump	☐ Fibromyalgia	☐ Kidney Disease	☐ Prostate Problems	☐ Tuberculosis
☐ Bronchitis	☐ Glaucoma	☐ Liver Disease	☐ Prosthesis	☐ Tumors, Growths
☐ Bulimia	☐ Goiter	☐ Measles	☐ Psychiatric care	☐ Ulcers
☐ Cancer	☐ Gonorrhea	☐ Migraines	☐ Rashes Skin	☐ Venereal Disease
☐ Cataracts	☐ Juvenile RA	☐ Mononucleosis	☐ Rheumatic Fever	☐ Whooping Cough
☐ Anxiety	☐ Ovarian Cyst(s)	☐ Pelvic Inflammatory disease		☐ Bowel Disease

☐ Other _____

IMMEDIATE FAMILY HISTORY

Do any of your blood relatives have any of the major health problems below? ? ☐ Yes ☐ No If yes, then who?
(Include whether the family member is on the <u>maternal</u> or <u>paternal</u> side of your family)

☐ AIDS_____	☐ Degenerative Disc/Arthritic disease	☐ Migraines_____
☐ Aneurysm/ Brain_____	_____	☐ Neurofibromatosis_____
☐ Asthma_____	☐ Diabetes_____	☐ Polycystic Kidney_____
☐ Bladder disease_____	☐ Epilepsy_____	☐ Psychological Disorder_____
☐ Blood vessel disease_____	☐ Heart Disease_____	☐ Spina Bifida_____
☐ Cancer_____	☐ High Blood Pressure_____	☐ Stroke_____
Type: _____	☐ Lung Disease_____	☐ Bowel Disease_____
☐ Osteoporosis_____	Type: _____	☐ Other_____

The above information is accurate and complete to the best of my knowledge. I will not hold my physician or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____