DRAEGER CHIROPRACTIC

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Patient Health History

Today's Date: _______________ ☐ **New Patient** ☐ **Reactivate (1 year +)** **Date Pain Began:** _______________

Personal Information

Name:____ Date of Birth: _________________ Current Age: ____________

Address: ____ Home Phone: ___________________________

City/St/Zip: ____ Cell Phone: _____________________________

E-Mail Address: ____ Work Phone: ___________________________

Emergency Contact(s): ____

Emergency Contact(s) Phone Number(s):____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Additional Category(specify): ________________ ☐ Decline to Answer

Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: __________ ☐ Student ☐ Full-time ☐ Part-time

Who is your primary medical doctor? __________________________________ **Location:** ________________________________

Insurance Information

Primary Insurance: _________________________________ Secondary Insurance: _____________________________________

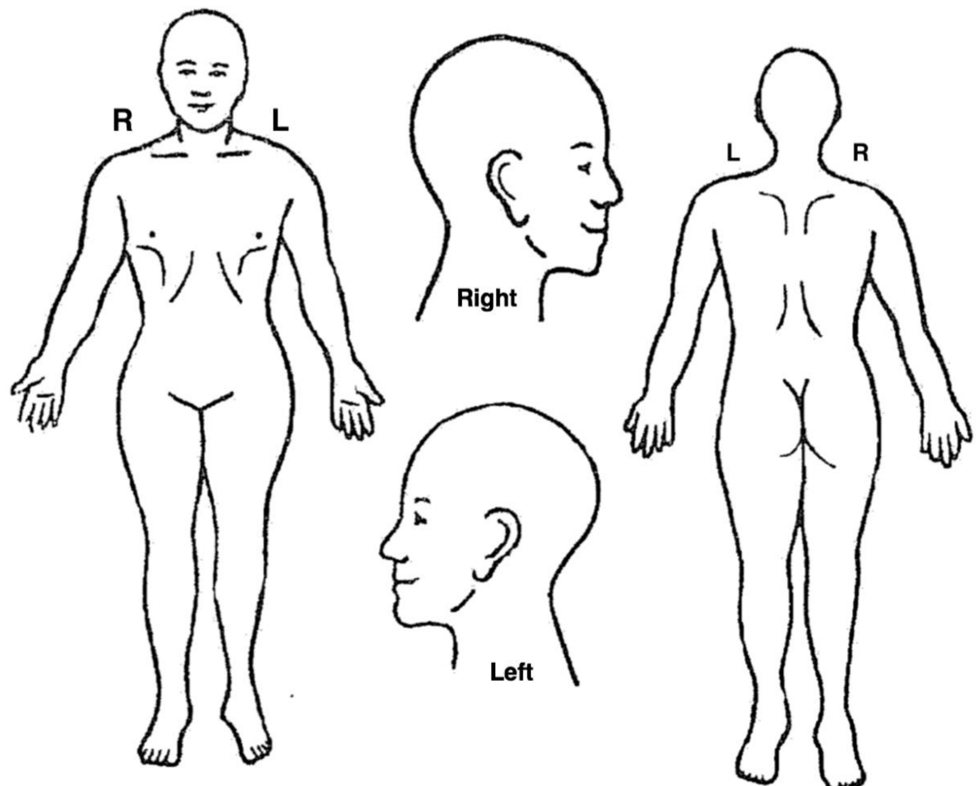
Insurance Subscriber's Name: _________________________________ Subscriber's Date of Birth: _______________________

Relationship to Subscriber: ________________ Social Security #: ______-______ -______ Effective Date: _______________

About Your Pain

Be sure to fill out this section as accurately as possible. Mark the area with the described sensation, using the appropriate symbols.

XXX Burning (BU)
(((Aching Pain (AC)
000 Pins & Needles (PI)
- - - Numbness (NU)
: : : Sharp Pains (SH)



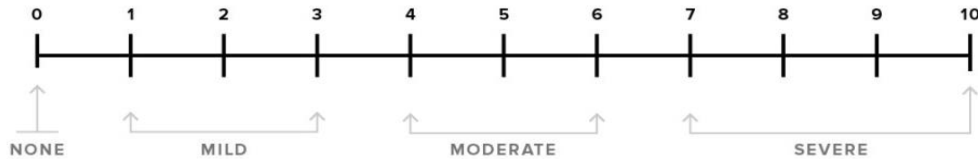
About Your Pain (Cont'd)

Location(s) of Pain: ____

How did this occur? ______________________________ When did this occur? ________________

Have you consulted any other physicians? ☐ **Yes** ☐ **No** If yes, **WHO** and **WHEN**? ______________________

Please rate your pain using the scale below. If there is more than one area of pain, please indicate the level of each area.



Please answer the next four (4) questions using the scale of 0-10 with 0 being no pain and 10 being the worst pain.

1. What is your pain level right now? ________________
2. What is your pain level most of the time? ____________
3. What is your pain level at its best? ________________
4. What is your pain level at its worst? ________________

How often are you at a pain level of zero?
- A. Once a day
- B. Once a week
- C. Once a month
- D. Never
- E. Other _____________

☐ **Yes** ☐ **No** Does the pain interfere with your sleep?
How often do you wake up per night? ______________

☐ **Yes** ☐ **No** Does weather affect your pain?
Explain: ________________________________

Using the codes below, indicate your ability to perform each of the following activities:

U – Unable **L – Limited** **P – Painful** **D – Difficult** **N – Normal** **H – Have not tried**

___Lying on back ___Reaching ___Kneeling ___Walking short distances
___Lying on side, knees bent ___Gripping ___Bending forward ___Standing more than 1 hour
___Lying on stomach ___Climbing ___Dressing self ___Balancing
___Turning over in bed ___Pulling ___Sexual activity ___Cough/Sneeze - if painful, answer below:
___Getting in/out of a car ___Pushing ___Sitting Where?__________________________

"BECAUSE OF THE PAIN" - Please check all that apply:

☐ I stay home most of the time.
☐ I change position(s) frequently.
☐ I walk more slowly than normal.
☐ I am not doing any jobs around the house.
☐ I lie down to rest more often.
☐ I have to hold onto something to get out of a chair.
☐ I have other people do things for me.
☐ I get dressed more slowly.
☐ I only stand up for short periods of time.
☐ I use a handrail to get upstairs.
☐ I try not to bend or kneel down.
☐ My appetite is not very good.
☐ I have trouble putting on my socks.
☐ I can only walk short distances.
☐ I sleep less.
☐ I sit down most of the day.
☐ I avoid heavy jobs around the house.
☐ I am more irritable and bad tempered.
☐ I stay in bed most of the time.
☐ I go up and down stairs more slowly.
☐ I have pain almost all of the time.
☐ I require help to get dressed.

Have you ever had problems with any of the following areas?

☐ Eyes ☐ Nose ☐ Lungs/Breathing ☐ Urinary ☐ Nerves ☐ Internal Organs
☐ Ears ☐ Mouth/Throat ☐ Intestines ☐ Muscles ☐ Blood ☐ Allergies

Please Explain: ____

____

Past Health History

Medical History

How many times have you had the condition that you are being seen for today? ☐ 0-3 times ☐ 4 or more times

☐ **Yes** ☐ **No** Do you suffer from any condition other than that for which you are consulting us? (Diabetes, High Blood Pressure, Heart Disease, Stroke, Arthritis, Cancer etc.) If yes, **WHAT**? ______________________________

☐ **Yes** ☐ **No** Have you seen a Chiropractor before? If yes, **WHO, WHEN** and for **WHAT**? ______________________________

______________________________ **Results: ☐ Complete Recovery ☐ Complications**

☐ **Yes** ☐ **No** Have you seen any other doctor for this condition? If yes, **WHO** and **WHEN**? ______________________________

______________________________ **Results: ☐ Complete Recovery ☐ Complications**

☐ **Yes** ☐ **No** Have you ever had any major illnesses, injuries, hospitalizations, auto accidents or surgeries? **WHEN** and **WHAT** condition? ______________________________

______________________________ **Results: ☐ Complete Recovery ☐ Complications**

If more space is required to fully answer this question, use the back of this sheet and indicate that you have done so.

Medication

☐ **Yes** ☐ **No** Do you have any allergies? If yes, to **WHAT**? ______________________________

Please list any prescription drugs, over-the-counter drugs, vitamins or supplements: ______________________________

____

If more space is required to fully answer this question, use the back of this sheet and indicate that you have done so.

Family History

Select any medical conditions of your blood relative(s) (mother, father, brother(s), sister(s) or children) below:

☐ **Cardiovascular Disease (Heart Disease)** **WHO:** ______________________________

☐ **Diabetes (Type I or II)** **WHO:** ______________________________

☐ **Cancer (Type)** **WHO:** ______________________________

☐ **Arthritis** **WHO:** ______________________________

Social History

What is your occupation? ______________________________ Number of work hours per week: __________

☐ **Yes** ☐ **No** Do you commute to work? How far per day? ______________________________

☐ **Yes** ☐ **No** Do you exercise? How often per week? ______________________________

Treatment Goals – Please tell us what you would like to achieve during your treatment: ______________________________

____

My signature is an acknowledgement that all of the above statements are true and accurate. I hereby authorize the doctor to examine and treat my condition(s) as he/she deems appropriate based on the information provided in this document.

Patient Signature: ______________________________ **Date:** ____________

Parent/Guardian/Legal Representative Signature: ______________________________

DC/CT Initials: __________ **Date:** ______________