Health History Information

Full Name:	Middle:	Marital Status (circle one) Single / Mar / Div / Sep / Widow	
Email:	Birth date:	Age:	Sex:
Address:	City:	State:	
ZIP Code: Social Security No.	Home Phone:		
Occupation: Employer	Work Phone:	Cell Phone:	
Who referred you here? We would like to thank them.			

Previous Care Information

Do You Have a Medical Doctor? (MD) ❑ No ❑ Yes, Name of Doctor:

Do You Have a Chiropractic Doctor? (DC) ❑ No ❑ Yes, Name of Doctor:

Date of last Visit: / / | was this to MD or DC?

Please list any medication and orther **allergies**:

Have you had surgeries, spinal or other: ❑ Yes ❑ No If yes, Last Surgery Date:

Reason for Surgery:

Social History

Alcohol? ❑ No ❑ Yes Drinks per week?	Sitting Job? ❑ No ❑ Yes Hours per day	Caffeine? ❑ No ❑ Yes Drinks per day?	Exercise? ❑ No ❑ Yes Hours per week: (Circle One) Light / Moderate / Strenuous

Daily Water Consumption: | Hobbies and Recreational Activities:

Smoke? Packs Per Day _________

❑ Current every day smoker ❑ Current some day smoker ❑ Former smoker ❑ Never ❑ _________________ Date Started

Have you ever been treated for drug or alcohol abuse or used illegal drugs? ❑ No ❑ Yes ❑ _________________ Date Stopped

Medications + Supplements List

Medication Name	Dose	Form	Route	Frequency	Date Started

Continue on Backside if Needed

Race: ☐ White ☐ African American ☐ Asian ☐ Am Indian or AK Native ☐ Native Hawaiian or other Pacific Islander ☐ Decline

Preferred Contact: ☐ Phone ☐ Email ☐ Text ☐ Other: ________________________________

PLEASE MARK HERE IF YOU HAVE **MEDICARE or Medicaid** AS YOUR PRIMARY INSURANCE _______

Is this due to: ☐ Automobile Injury ☐ Work-Related Injury

Payment will be required at the time services are rendered, unless other arrangements are made in advance.

AUTHORIZATION AND RELEASE: I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, research, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand there will be a fee added to overdue accounts.

Signature: ____ Date: __________________________

Parent/Guardian (If under 18 yrs old): ________________________________ Date: __________________________

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

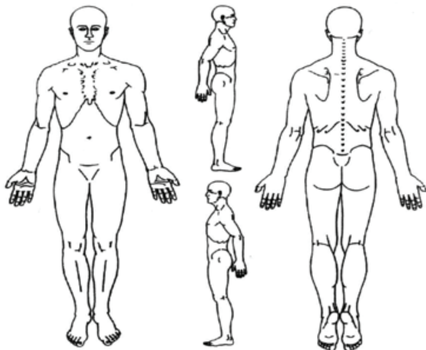
Patient Health Questionnaire

Name: ______________________________ Date: ______________

Please describe your chief concern: ______________________________

When did it begin? ______________ **How did it begin?** ______________________

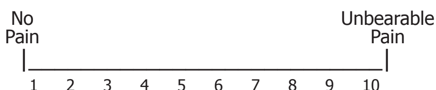
(Mark the area of pain/symptoms) (Dr. Notes)



(Front) (Back)

Description		**Frequency**	What Makes Concern **Better?**		What Makes It **Worse?**	
☐ Sharp	☐ Numb	☐ Constant (76–100%)	☐ Nothing	☐ Sitting	☐ Nothing	☐ Sitting
☐ Dull	☐ Shooting	☐ Frequent (51–75%)	☐ Lying Down	☐ Exercise	☐ Lying Down	☐ Exercise
☐ Ache	☐ Gripping	☐ Occasional (26–50%)	☐ Walking	☐ Inactivity	☐ Walking	☐ Inactivity
☐ Weak	☐ Burning	☐ Intermittent (25% or less)	☐ Standing	☐ Ice/Heat	☐ Standing	☐ Ice/Heat
☐ Throbbing	☐ Tingling					

INDICATE the intensity of your pain at it's **LOWEST** & **HIGHEST** level.



Current weight _____ lbs

height ________

Your Symptoms are:

☐ Decreasing
☐ Not Changing
☐ Increasing

Worse at:

☐ Morning
☐ Night
☐ Daytime
☐ Same all day

Please rate your stress level

☐ No Stress
☐ Mild Stress
☐ Moderate Stress
☐ Significant Stress

Has this concern impacted your level of stress?

☐ Yes ☐ No

Indicate any tests or treatments that you have had for this condition (include location and year):

☐ Injection ______________ ☐ Surgery______________

☐ X-rays ______________ ☐ MRI______________

☐ CT/CAT Scans ______________ ☐ EMG ______________

☐ Physical Therapy ______________ ☐ Other ______________

How is your concern affecting daily activities?

☐ No effect
☐ Able to perform light duty only
☐ Need assistance with common tasks
☐ Inability to function without assistance
☐ Totally impaired/disabled

Current Work Status

☐ Full Time ☐ Unemployed
☐ Part Time ☐ Retired
☐ Off Work ☐ Full-time student
☐ Restrictions ☐ Other

Work Description: ______________

☐ I have received the HIPPA Privacy Practice Act from Brown Chiropratic

Brown Chiropractic Signature: ______________________ Date: ______________

SYSTEMS REVIEW

Name: ______________________________ Date: ______________

Name of Person Filling out Form is other than the patient: ______________________________

Please indicate whether you have ever sought care or have had a health problem related to any of the following.

Musculoskeletal (Past)

- ☐ Neck Pain
- ☐ Jaw Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Wrist/Hand Pain
- ☐ Mid-back Pain
- ☐ Low-back
- Pain Radiates to arm/leg
- ☐ Hip-Thigh Pain
- ☐ Knee-Leg Pain
- ☐ Ankle/Foot Pain
- ☐ Joint Stiffness/Swelling
- ☐ Fracture ______________
- ☐ Arthritis past/present
- ☐ Other ______________

Explain:

Cardiovascular - Repiratory

PAST	PRESENT		PAST	PRESENT	
☐	☐	High Blood Pressure	☐	☐	Rapid Heart Beat
☐	☐	High Cholesterol	☐	☐	Slow Heart Beat
☐	☐	Heart Attack	☐	☐	Narrowed Coronary Arteries
☐	☐	Stroke	☐	☐	Cough
☐	☐	Angina (Chest Pain)	☐	☐	Wheezing
☐	☐	Heart Valves	☐	☐	Lungs
☐	☐	Breathing Difficulties	☐	☐	Other______________
☐	☐	Aortic Aneurysm			
☐	☐	Emphysema			

Explain:

Neurologic

PAST	PRESENT		PAST	PRESENT	
☐	☐	Headache	☐	☐	Weakness
☐	☐	Fainting	☐	☐	Tremor
☐	☐	Visual Problems	☐	☐	Vertigo
☐	☐	Dizziness	☐	☐	Brain
☐	☐	Incoordination	☐	☐	Alzheimer's
☐	☐	Tinnitus (Ear noises)	☐	☐	Parkinson's
☐	☐	Seizure	☐	☐	Neuropathy
☐	☐	Paralysis	☐	☐	Diabetes I/II

Gastro-Intestinal

PAST	PRESENT		PAST	PRESENT	
☐	☐	Swallowing Difficulty	☐	☐	Abdominal Pain
☐	☐	Heartburn-Indigestion	☐	☐	Appetite Loss
☐	☐	Excessive Thirst	☐	☐	Abnormal Weight Gain/Loss
☐	☐	Constipation-Irregular Bowell	☐	☐	Ulcerative Colitis
☐	☐	Irritable Bowell	☐	☐	Chrohn's Disease
☐	☐	Ulcer	☐	☐	Liver/Gallbladder Problems
☐	☐	Hernia	☐	☐	Pancreas
☐	☐	Nausea	☐	☐	Vomiting
☐	☐	Obesity	☐	☐	Other______________
☐	☐	Gastro-Esophageal Reflux			

Explain:

Hormonal

PAST	PRESENT		PAST	PRESENT	
☐	☐	Depression	☐	☐	Uterus
☐	☐	PMS premenstrual synd.	☐	☐	Ovaries
☐	☐	Irregular Menstruation	☐	☐	Prostate
☐	☐	Profuse Menstrual Flow	☐	☐	Testicles
☐	☐	Menstrual Cramps	☐	☐	Other______________
☐	☐	Breast Soreness/Lumps	☐	☐	Mental Illness
☐	☐	Endometriosis			

Explain:

Immune

PAST	PRESENT		PAST	PRESENT	
☐	☐	Asthma	☐	☐	Chronic Fatigue
☐	☐	Allergies	☐	☐	General Fatigue
☐	☐	Lupus	☐	☐	Chronic Infections
☐	☐	Rheumatoid Arthritis	☐	☐	Spleen
☐	☐	Cancer______________	☐	☐	Other______________
☐	☐	Fibromyalgia			

SYSTEMS REVIEW

Name: ______________________________ Date: ______________

Please indicate whether you have ever sought medical care or have had a medical problem related to each of the following.

ENT

PAST	PRESENT	
☐	☐	Eyes
☐	☐	Ears
☐	☐	Nose
☐	☐	Throat
☐	☐	Sinus
☐	☐	Tonsils

Skin

PAST	PRESENT	
☐	☐	Dermatitis-Psoriasis
☐	☐	Excema-Rash
☐	☐	Acne
☐	☐	Shingles
☐	☐	Slow Wound Healing

Urinary

PAST	PRESENT	
☐	☐	Bladder Infection
☐	☐	Kidney Stones
☐	☐	Candida
☐	☐	Prostate Problems
☐	☐	Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Kidney Disorder
☐	☐	Other____________

Explain:

FAMILY HEALTH HISTORY

Indicate which primary family members (Grandparent, Father, Mother or Sibling) with any of the following conditions:

G = Grandparent **F** = Father **M** = Mother **S** = Sibling

G	F	M	S	
☐	☐	☐	☐	Alcoholism
☐	☐	☐	☐	Allergies
☐	☐	☐	☐	Alzheimer’s Disease
☐	☐	☐	☐	Anemia
☐	☐	☐	☐	Arthritis
☐	☐	☐	☐	Asthma
☐	☐	☐	☐	Bleeding Disorders
☐	☐	☐	☐	Breast Cancer
☐	☐	☐	☐	Cancer
☐	☐	☐	☐	Cardiovascular Disease
☐	☐	☐	☐	Cerebrovascular Disease
☐	☐	☐	☐	Crohn’s Disease
☐	☐	☐	☐	Degernative Joint Disease
☐	☐	☐	☐	Depression
☐	☐	☐	☐	Diabetes
☐	☐	☐	☐	Eczema
☐	☐	☐	☐	Epilepsy
☐	☐	☐	☐	Gastroesphagel Reflux (GERD)
☐	☐	☐	☐	Headaches
☐	☐	☐	☐	Heart Disease
☐	☐	☐	☐	High Cholesterol
☐	☐	☐	☐	Hypertension
☐	☐	☐	☐	Hyperthyroidism
☐	☐	☐	☐	Hypothyroidism
☐	☐	☐	☐	Kidney Disease
☐	☐	☐	☐	Lupus
☐	☐	☐	☐	Mental Illness
☐	☐	☐	☐	MS
☐	☐	☐	☐	Osteoporosis
☐	☐	☐	☐	Parkinson’s Disease
☐	☐	☐	☐	Prostate Cancer
☐	☐	☐	☐	Rheumatoid Arthritis
☐	☐	☐	☐	Seizures
☐	☐	☐	☐	Skin Cancer
☐	☐	☐	☐	Stroke
☐	☐	☐	☐	Ulcerative Colitis

1. Leave Blank

yes _________ No _________ Date ________________
yes _________ No _________ Date ________________