

# CONFIDENTIAL PATIENT HISTORY

## PATIENT INFORMATION

WHO MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_ Date \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ email \_\_\_\_\_  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex M F Married ( ) Single ( ) SS# \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
Spouse/Parent Name \_\_\_\_\_ Employer \_\_\_\_\_ # Children \_\_\_\_\_

## PATIENT CONDITION

Describe Major Complaint(s) \_\_\_\_\_

When did it start? \_\_\_\_\_ Is it getting progressively worse Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had injuries which gave similar symptoms in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain \_\_\_\_\_

What percentage of the day are you in pain or discomfort? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Please rate your pain (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Type of pain: \_\_\_\_\_sharp \_\_\_\_\_dull \_\_\_\_\_throbbing \_\_\_\_\_numbness aching \_\_\_\_\_shooting \_\_\_\_\_Burning \_\_\_\_\_tingling  
\_\_\_\_\_cramps \_\_\_\_\_stiffness \_\_\_\_\_swelling \_\_\_\_\_boring \_\_\_\_\_heavy, pressing \_\_\_\_\_other

Do you have any difficulty with: (circle any that apply) bowel – bladder – sexual function – none

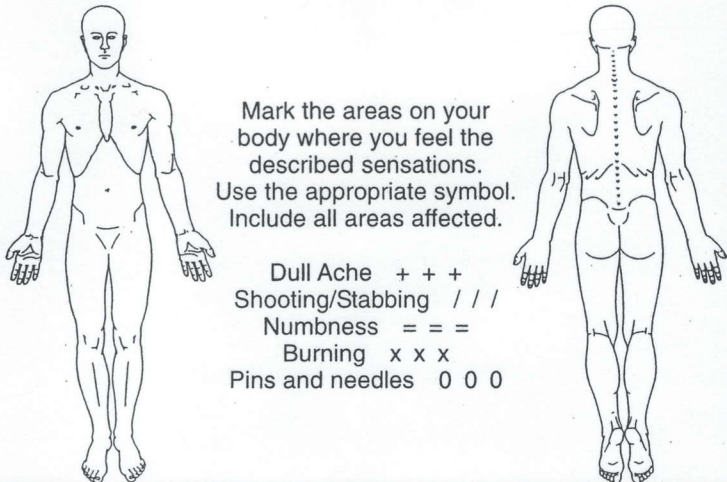
How does the pain affect your personality? Please check:

- \_\_\_\_\_ normal, no effect, alert, cheerful
- \_\_\_\_\_ slightly, upset, irritable, complaining
- \_\_\_\_\_ moderately, upset, unhappy, anxious
- \_\_\_\_\_ severely upset, depressed, bitter
- \_\_\_\_\_ totally incapacitated, avoid everyone

Has the pain affected any of the following?

- \_\_\_\_\_ employment
- \_\_\_\_\_ social life
- \_\_\_\_\_ interpersonal relations
- \_\_\_\_\_ specific physical activities
- \_\_\_\_\_ recreational activities

Do you feel this pain: superficial (close to the skin)? \_\_\_\_\_  
or deep (inside body or limb)? \_\_\_\_\_



Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all areas affected.

Dull Ache + + +  
Shooting/Stabbing / / /  
Numbness = = =  
Burning x x x  
Pins and needles 0 0 0

## PROTECTED HEALTH INFORMATION

### Information to Be Disclosed:

- We may post your name on our referral board to thank you for referring a new patient to us. We may also send a thank you card to the person who referred you to our office.
- We may ask you if you would like to share how Chiropractic has helped you with a written testimonial. If you accept, we may use it along with your name and picture in promotional activities.
- If you have a child who is a patient here we may ask if you would allow us to post their picture and first name on a bulletin board With other children who are patients here.

### Persons Authorized to Use or Disclose Information:

Cummings Family Chiropractic P.C., 1520 Midland Ct NE, Suite 100, Cedar Rapids, IA 52402

- Information described above may be disclosed to current, new patients and the general public. This authorization is effective for 5 years unless revoked or terminated by the patient. You may revoke or terminate this authorization by submitting a written revocation to Cummings Family Chiropractic. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under federal privacy regulations.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  
 Chiropractic Services  None  Other \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
 Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Family physician's name: \_\_\_\_\_

Prior chiropractor's name: \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scoliosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anorexia/Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Type _____ Year _____			Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other _____		
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

<p style="text-align: center;"><b>EXERCISE</b></p> <p>Times Per Week _____</p> <p>Activity _____</p>	<p style="text-align: center;"><b>WORK ACTIVITY</b></p> <p><input type="checkbox"/> Sitting</p> <p><input type="checkbox"/> Standing</p> <p><input type="checkbox"/> Light Labor</p> <p><input type="checkbox"/> Heavy Labor</p>	<p style="text-align: center;"><b>HABITS</b></p> <p><input type="checkbox"/> Smoking</p> <p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Coffee/Caffeine Drinks</p> <p><input type="checkbox"/> High Stress Level</p>	<p>Packs/Day _____</p> <p>Drinks/Week _____</p> <p>Cups/Day _____</p> <p>Reason _____</p>
<p><b>DIET</b></p> <p><input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good</p>			

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____