Mary G. Elsea, D.C.
Elizabeth Decker, D.C.
Christopher Rowenhorst, D.C
Hillary Bauman, D.C.

Patient Name_____________________
Date______________________

Patient History

TESTS: Please list the MOST recent date:

Physical Exam___________ Spinal X-Ray________ MRI/CT/Bone Scans_____________ Blood Test___________
Spinal Exam ____________ Chest X-Ray _________ EKG_______________ Urine Test___________

HABITS:	**YES**	**NO**	**If yes, please describe:**
Smoking			Packs per day: 0 – ½ ½ - 1 2 or more Duration __________
Alcohol Consumption			# Drinks per day ________ Drinks per week __________
Coffee or Tea Consumption			Cups per day ___________
Other Drug Use (Street Drugs)			______________________________________
Exercise			Daily Weekly Monthly Type ______________________

Work Activities Sitting Standing Light labor Heavy labor

High Stress Y N Sleep Position_____________________________ Number of Hours sleep/night_____________

HOBBIES OR INTEREST: ____

MEDICATIONS: Please list all currently used medicines. Include prescription and non-prescription drugs, vitamins, herbs
____

ALLERGIES: Please list all known allergies, especially to medicines. _______________________________________

Treatment you are receiving or have received:

Medical care Chiropractic care Other ____
Name(s) of other doctor(s) who have treated you for this condition_________________________________
What treatment was recommended? _______________Length of time under care?_______________Results?__________________

Please mark all that apply:

	Current	**Past**
History of trauma		
Infection		
Unexplained weight loss		
Unusual fatigue		
Depression		
Dizziness / Poor balance		
Vomited blood		
Bloody or black stools		
Change in appetite		
Fevers		
Night Sweats		
High blood pressure		
Chest Pain		
Shortness of breath		
Chronic cough		
Stroke		
Heart disease or murmur		
Loss of bowel or bladder control		
Headaches		
Muscle weakness/paralysis		
Memory loss		
Severe trauma		
Direct head trauma		
Lost consciousness		
Poor coordination		
Night pain		
Difficulty Swallowing		

Please mark all that apply:

	Current	**Past**
Recent infection		
History of osteoporosis		
History of cancer		
Difficulty breathing		
Abdominal pain		
Use of corticosteroids		
Use of anticoagulants		
Use of birth control pills		
Numbness in groin (saddle anesthesia)		
Loss of anal sphincter tone, fecal incontinence (bowel accidents)		
Pain fails to improve with rest		
Spinal pain greater than 4 weeks		
Prolonged use of corticosteroids		
Intravenous drug use		
Back pain, stiffness, or weakness		
Neck pain, stiffness, or weakness		
Muscle spasm in neck or back		
Shoulder pain (R / L)		
Hip/buttock pain (R / L)		
Knee/ankle/foot pain (R / L)		
Swollen or painful joints		
Cold hands or feet		
Numbness or pain in the arms, hands or fingers (R / L)		
Numbness or pain in the legs, feet or toes (R / L)		

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CONDITIONS: Please mark current (C) or past (P) to indicate the following:

Condition	C/P	Condition	C/P	Condition	C/P	Condition	C/P
AIDS/HIV	□C□P	Diabetes	□C□P	Measles	□C□P	Rheumatoid Arthirtis	□C□P
Alcoholism	□C□P	Emphysema	□C□P	Migraine Headaches	□C□P	Rheumatic Fever	□C□P
Allergy Shots	□C□P	Epilepsy	□C□P	Miscarriage	□C□P	Scarlet Fever	□C□P
Anemia	□C□P	Fractures	□C□P	Mononucleosis	□C□P	Seizures	□C□P
Anorexia	□C□P	Glaucoma	□C□P	Multiple Sclerosis	□C□P	Stroke	□C□P
Appendicitis	□C□P	Goiter	□C□P	Mumps	□C□P	Suicide Attempt	□C□P
Arthritis	□C□P	Gonorrhea	□C□P	Osteoporosis	□C□P	Thyroid Problems	□C□P
Asthma	□C□P	Gout	□C□P	Pacemaker	□C□P	Tonsillitis	□C□P
Bleeding Disorders	□C□P	Heart Disease	□C□P	Parkinson's Disease	□C□P	Tremors	□C□P
Breast Lump	□C□P	Hepatitis	□C□P	Pinched Nerve	□C□P	Tuberculosis	□C□P
Bronchitis	□C□P	Hernia	□C□P	Pneumonia	□C□P	Tumors/Growths	□C□P
Bulimia	□C□P	Herniated Disc	□C□P	Polio	□C□P	Ulcers	□C□P
Cancer	□C□P	Herpes	□C□P	Polyps	□C□P	Vaginal Infections	□C□P
Cataracts	□C□P	High Cholesterol	□C□P	Prostate Problem	□C□P	Venereal Disease	□C□P
Chemical Dependency	□C□P	Kidney Disease	□C□P	Prosthesis	□C□P	Whooping Cough	□C□P
Chicken Pox	□C□P	Liver Disease	□C□P	Psychiatric Care	□C□P	Other _______________	

GENERAL SYMPTOMS: Please mark current (C) or past (P) to indicate the following:

GENERAL	
Bruise easily	□C□P
Chills	□C□P
Dental problems	□C□P
Depression	□C□P
Difficulty sleeping	□C□P
Dizziness	□C□P
Fainting	□C□P
Fever	□C□P
Forgetfulness	□C□P
Headache	□C□P
Loss of sleep	□C□P
Loss of weight	□C□P
Nervousness	□C□P
Numbness	□C□P
Sweats	□C□P
Tiredness	□C□P
Weight gain	□C□P

GENITOURINARY	
Blood in urine	□C□P
Frequent urination	□C□P
Lack of bladder control	□C□P
Painful urination	□C□P
Bladder infection	□C□P

GASTROINTESTINAL	
Appetite poor	□C□P
Bloating	□C□P
Bowel changes	□C□P
Constipation	□C□P
Diarrhea	□C□P
Excessive hunger	□C□P
Excessive thirst	□C□P
Gas	□C□P
Hemorrhoids	□C□P
Indigestion	□C□P
Nausea	□C□P
Rectal bleeding	□C□P
Stomach pain	□C□P
Vomiting	□C□P

CARDIOVASCULAR	
Chest pain	□C□P
High blood pressure	□C□P
Irregular heart beat	□C□P
Low blood pressure	□C□P
Poor circulation	□C□P
Rapid heart beat	□C□P
Swelling of ankles	□C□P
Varicose veins	□C□P

EYE EAR NOSE THROAT	
Bleeding gums	□C□P
Blurred vision	□C□P
Crossed eyes	□C□P
Difficulty swallowing	□C□P
Double vision	□C□P
Earache	□C□P
Ear discharge	□C□P
Hay fever	□C□P
Hoarseness	□C□P
Loss of hearing	□C□P
Nosebleeds	□C□P
Persistent cough	□C□P
Ringing in ears	□C□P
Sinus problems	□C□P
Vision- flashes/halos	□C□P

SKIN	
Bruise easily	□C□P
Hives	□C□P
Itching	□C□P
Change in moles	□C□P
Rash	□C□P
Scars	□C□P
Sore that won't heal	□C□P

MEN only	
Breast lump	□C□P
Erection difficulties	□C□P
Lump in testicles	□C□P
Penis discharge	□C□P
Sore on penis	□C□P
Other	□C□P

WOMEN only	
Abnormal pap smear	□C□P
Bleeding b/t periods	□C□P
Breast lump	□C□P
Extreme menstrual pain	□C□P
Hot flashes	□C□P
Nipple discharge	□C□P
Painful intercourse	□C□P
Vaginal discharge	□C□P

Other_____________

Date of last menstrual period_____

Date of last pap smear______

Have you had mammogram? ____

Are you pregnant?_____

Number of children_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Name, Printed ____

Patient Signature ____ Date _____________

Doctor Signature ____ Date _____________

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ABOUT YOUR FAMILY HISTORY:
Please mark relative's current age or age at time of death, place an X in the boxes that apply to them. Describe "Other" and list cause of death

	Age	Allergy – Asthma	Alcohol Abuse	Arthritis – Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or back disorder	Stroke	Tuberculosis	Chronic Pain	Other	If deceased, cause of death
Mother's Mother																				
Mother's Father																				
Father's Mother																				
Father's Father																				
Father																				
Mother																				
Brother's & Sisters #1																				
#2																				
#3																				
#4																				
#5																				
Spouse																				
Children #1																				
#2																				
#3																				
#4																				
#5																				

HOSPITALIZATIONS, OPERATIONS, AUTO & ON THE JOB INJURIES

AREAS INVOLVED INDICATE

EVALUATIONS & TREATMENT

(Please be as specific as possible) Year

1.
2.
3.
4.
5.

SERIOUS ILLNESSES: List current and past illnesses not mentioned above. (Including cancer, diabetes, etc.)

1.
2.
3.
4.
5.

Patient Name, Printed ______________________________

Patient Signature ______________________________ Date ______________

Doctor Signature ______________________________ Date ______________

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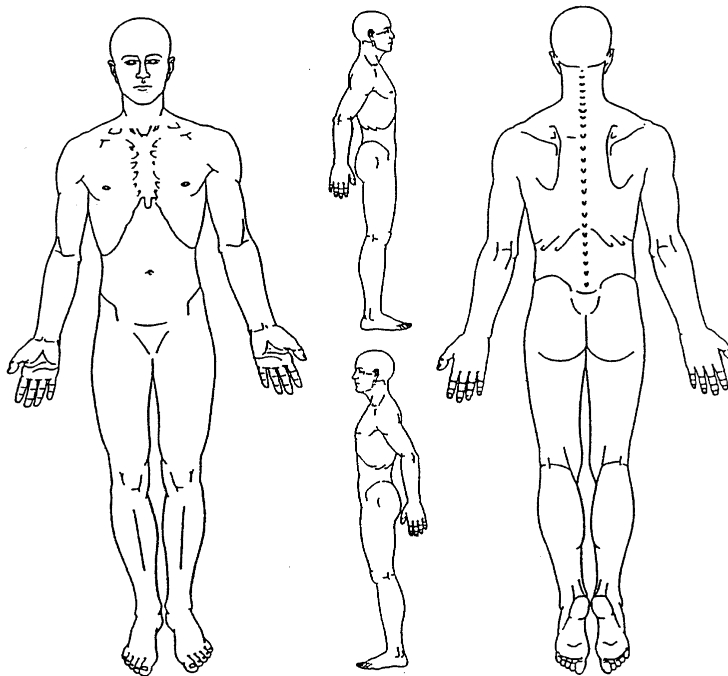
Pain Location, Intensity & Frequency Questionnaire

Reason for Visit:____
Other Concerns/Symptoms:____
Comments:____
When did your symptoms appear?____
Have you had similar symptoms in the past? Y N When?______________________________

Please use the codes below to explain and locate the areas that are bothering you.

Key

Use letters below to indicate type and location of discomfort		
A = Ache	B = Burning	S = Stabbing
N = Numbing	P = Pins & Needles	O = Other



Please rate the Intensity & Frequency of your pain using 0 – 10 Pain scale
(0=No pain, 10=Most severe imaginable)

Present pain level ___; Average pain level ___; pain present ___% of the time;
Worst pain level ___, present ___% of the time; lowest pain level ___, present ___% of time.
What will increase your pain?____
What gives you the greatest relief/contol of pain?_______________________________________
Is this condition getting progressively worse? Y N Unknown
Symptoms present in Morning Afternoon Evening Night Constant
What are you unable to do because of your pain?__________________________________

What are your goals for this visit?____

Patient Name, Printed ____________________________ Date ____________________

Patient Signature_________________________________ Doctor Signature___________________________