MT. LOOKOUT CHIROPRACTIC & SPORTS INJURY CENTER, INC. Date_____
CONFIDENTIAL PATIENT HISTORY

Dr's
MAK
DLM
EWE
SWK
JRP

Name_____ Male / Female Home Phone (____)_____

Address_____ Cell Phone (____)_____

City_____ST_____Zip_____Email_____

Age_____ Birth Date_____ Social Security#_____

Marital Status: M S W D O No. of Children____

Occupation_____ Employer_____
Address_____
Work Phone (____)_____
Name of Spouse_____ Spouse Social Security #_____
Spouse Employer_____ Work Phone (____)_____
Address _____

Name of Emergency Contact _____ Phone(____)_____
(Nearest relative, not spouse)

How do you prefer to be verbally addressed? _____

Whom may we thank for referring you? _____

Present Complaint_____
_____

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING, ETC.

When did your problem begin? Specific date if possible_____

How did your problem begin?_____
_____

In the past have you had anything similar to this? YES NO Please explain _____
_____

Please describe the character of your current pain. You may check one or more answers. ( ) Sharp
( ) Stabbing ( ) Burning ( ) Shooting ( ) Aches ( ) Soreness ( ) Weakness
( ) Throbbing ( ) Numbness ( ) Dull ( ) Constricting ( ) Other _____
_____

On a Scale from 0-10, with 10 being the worst pain you have experienced and 0 being no pain. What is your current s
of pain? 0 1 2 3 4 5 6 7 8 9 10

How often are the complaints present? ( ) Constant/100% of time ( ) Frequent/75% ( ) Intermittent/50% ( ) Occasional/25% Comments:_____

Is the pain: ( ) Increasing ( ) Decreasing ( ) Not Changing

Pain is aggravated by: ( ) Walking ( ) Sitting ( ) Standing ( ) Riding in a car
( ) Lifting ( ) Bending ( ) Stretching ( ) Twisting ( ) Other _____

Pain is reduced by: Medicine, Exercise, Rest, Adjustments, Therapy _____

What would you like to do, but can't, because of your pain?_____
_____

Are your complaints affecting your ability to work or be active?
( ) No effect ( ) Some physical restrictions ( ) Unable to perform regular duties

Is there any dizziness associated with symptoms? YES NO_____
Any fever or chills? YES NO_____
Any change in bowel or bladder (bathroom) function? YES NO _____
Are your complaints affecting your ability to sleep? YES NO Explain: _____

For your present complaint have you seen any other doctors? YES NO If yes, who?_____
_____ What treatment?_____

FAMILY DOCTOR/PRIMARY CARE PHYSICIAN_____
We normally keep your family doctor and/or referring physician informed regarding your care at this office. Is that okay?
YES NO _____
Please specify name and address_____
_____
(Some managed care plans may require contact between our office and the referring physician)

Have you missed any days of work or school? YES NO Dates missed:_____
Have you ever broken any bones? YES NO Explain: _____
Please list any significant health history of parents and or siblings_____
_____
Have you been in the hospital or had surgery for any reason? YES NO Please explain_____
_____
_____
Have you ever been in an accident? YES NO Please explain_____
_____

What **non-prescription** medication are you taking? Tylenol ____ Ibuprofen ____ Aspirin ____Other _____

What **Prescription** Medications or Drugs are you taking?_____
Anti-inflammatory ____ Pain Killers _____ Muscle Relaxers _____ Blood Pressure Med _____
Insulin _____ Birth Control Pill _____ Tranquilizers _____ Diet Pills _____ Nerve Pills _____
HRT _____ Cholesterol Meds. _____ Sleeping Aid _____
Other _____

Do you smoke? YES NO How Much_____
Consume alcohol? YES NO How Much_____

What is your exercise routine? _____

Other health concerns: _____