EASTSIDE CHIROPRACTIC SERVICES
Tumwater, WA

Part 1

HEALTH HISTORY

We consider this information vital to determine the most accurate diagnosis. This also enables us to then determine the most appropriate care for your particular case. To assist us in gaining the maximum information, please complete this form **IN ITS ENTIRETY**. If you require help with any questions, please ask. Be accurate and as complete as possible.

Name _____ Birthday _____ Age _____

Address _____

Occupation _____ Employer _____

Today's date _____ Referred by _____

Part 2

Please list your symptoms in order of severity. Also circle a number that best describes the intensity and frequency of each symptom.

Symptom	Intensity (Mild … Severe)	Frequency (Rarely … Constant)
1. _____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
2. _____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
3. _____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
4. _____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
5. _____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
6. _____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
7. _____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
8. _____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

How did your symptoms start? When did they start?

What makes your symptoms better and worse?

Who is your family physician?

Past treatment of the above symptoms.

Please list all medicines or drugs (include prescription & over-the-counter) you are now taking.

DRUG	AMOUNT/DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List other conditions you are being treated for.

How does your current condition interfere with:

Work _____

Recreational activities _____

Household responsibilities _____

Personal relationships _____

Do you wear or have you ever worn:

inner soles _____

heel lifts _____

arch supports _____

other braces _____

Please indicate your approximate use or intake of the following:

Coffee _____ Soft Drinks _____

Tobacco _____ Water _____

Alcohol _____ Exercise _____

Other toxic or potentially dangerous substances or chemicals _____

Vitamins or minerals _____

Patient Name _____

Part 3

REVIEW OF SYSTEMS

Please circle any symptoms or conditions in this section which you now have or have had. If you have symptoms or conditions not in the list, please write them in.

Eye and Vision loss or change of vision; eye pain or redness; excessive watering; double vision; other _____

Ears and Hearing loss of hearing; ear noises; ear infection; discharge; ear pain; other _____

Nose and Throat hoarseness; excessive sneezing; nosebleeds; blocked nasal passages; difficulty swallowing; other _____

Respiratory wheezing; large amounts of phlegm; bloody phlegm; excessive cough; shortness of breath with slight exertion; pain with breathing; difficult breathing; other _____

Cardiovascular chest pain; abnormal heartbeat; abnormal blood pressure; excessive swelling of ankles or feet; leg cramps with walking; varicose veins; atherosclerosis; arteriosclerosis; other _____

Gastrointestinal difficult digestion; frequent nausea or vomiting; vomit blood; lack or loss of appetite; recent weight gain or loss; bloody stool; liver or gall bladder trouble; abdominal pain; ulcer; excessive hunger; other _____

Genital-Urinary urinary incontinence; bloody urine; burning with urination; excessive urine; scanty urine; increased urinary frequency; urgency of urination; difficulty starting urination; other _____

Male penile pain; infection or open sores; testicular pain or swelling; difficulty in sexual function; unusual discharge; other _____

Female breast/nipple discharge; unusual skin changes over breast; unusual breast lumps; known uterine, ovarian or breast problems; vaginal pain; itch or unusual discharge; cramps; unusual menses; difficulty in sexual functions; other _____

Neurological severe headaches; dizziness; fainting spells; seizures; convulsions; shaking or tremor; paralysis; numbness; memory changes; blackouts; muscle jerking; weakness; radiating pain; balance or coordination problems; overly sensitive skin areas; other _____

Emotional or Psychological Emotional illness; depression; excessive worry; severe tension; recurrent fear; insomnia; nervous breakdown; hysterical attack; confusion; other _____

Previous work comp claims or litigation involving injury, please explain _____

Please list any other medical or surgical conditions not previously listed _____

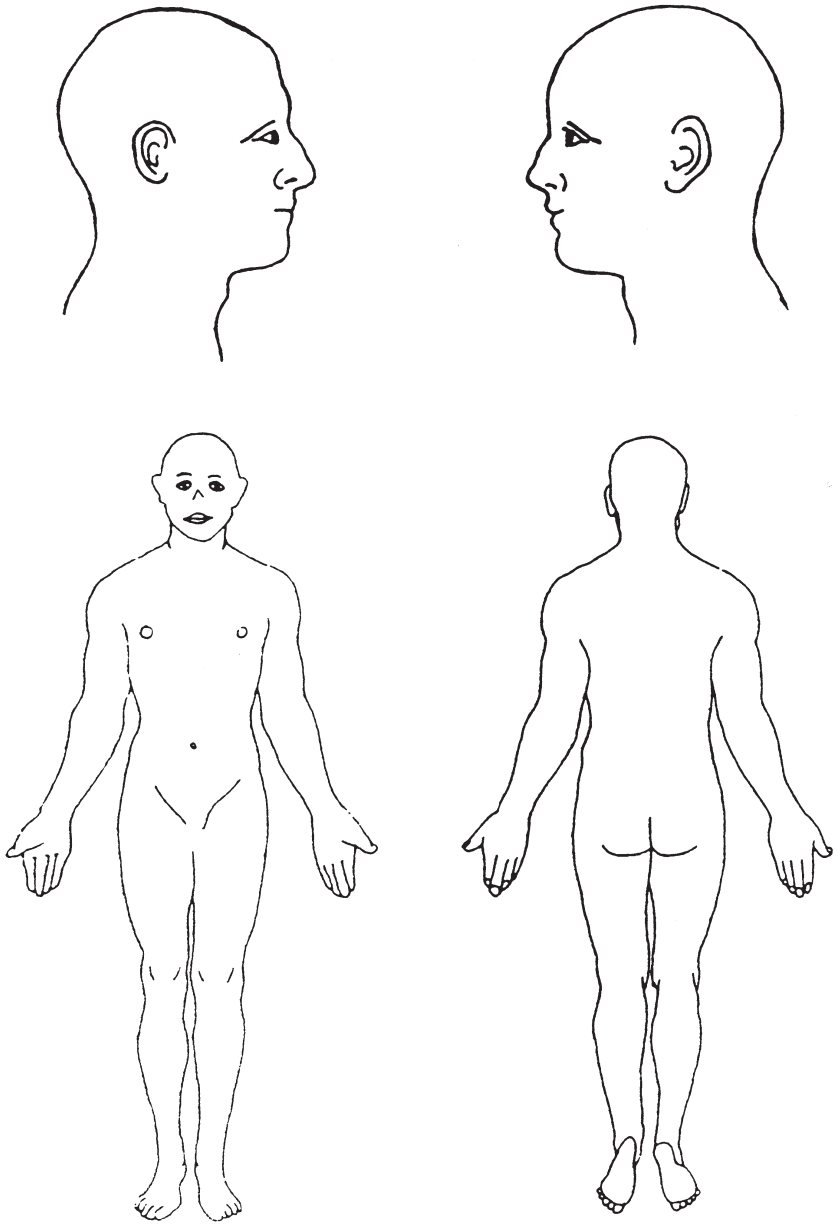
Patient Name _____

Part 4

PAIN CHART

Please mark the number on the drawing that most closely describes the sensations you feel. Use arrows to show radiating pain or odd sensations. Fill this out very accurately

1 numbness
2 tingling
3 burning
4 ache
5 sharp
6 throbbing
7 stabbing
8 pins & needles
9 other_____ (please describe)



do not write in this box

intermittent; constant

Family History

Relative	Age if living	State of Health good	poor	Illnesses	Age of death	Cause of death natural	illness
Mother	_____	☐	☐	_____	_____	☐	_____
Father	_____	☐	☐	_____	_____	☐	_____
Sister	_____	☐	☐	_____	_____	☐	_____
Brother	_____	☐	☐	_____	_____	☐	_____
_____	_____	☐	☐	_____	_____	☐	_____
_____	_____	☐	☐	_____	_____	☐	_____
_____	_____	☐	☐	_____	_____	☐	_____

Patient Name _____

Part 5

PAST HISTORY

Please list the approximate dates and types of the following (past & present).

Surgery:

Hospitalization:

Injuries:

Accidents: (car, motorcycle, bike, horse, etc...)

Illnesses:

Broken bones:

Concussion:

Previous neck or back injury:

The above is true to the best of my knowledge.

Signature _____ Date_____