LANGEL CHIRORPACTIC CLINIC, P.C.
PATIENT HEALTH HISTORY

Name: _____ Date _____ ID No. _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

□ Email Appointment Reminders □ Text Appointment Reminders: Cell Phone Carrier: _____

Email Address: _____ Occupation & Employer: _____

Date of Birth: _____ Social Security #: _____-_____-_____ Gender: Male - Female

Marital Status: _M _S _W _D Name of Spouse: _____

Primary Insurance _____ Secondary Insurance _____

Who is responsible for payment? □ Self □ Spouse □ Other _____ Mother's Maiden Name_____

How did you learn of this clinic? _____

Contact in case of emergency:_____Phone#_____-_____-_____

List any **Allergies**: _____

List any **Surgeries** and Date:_____

List **ALL Current Medical** conditions:

□ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain □ Heartburn □ Depression □ Diabetes
□ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain
□ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems □ Hepatitis □ High Blood Pressure
□ Hip Pain □ HIV □ Jaw Pain □ Joint Stiffness □ Knee Pain □ Leg Pain □ Menstrual Problems □ Mid-Back Pain
□ Minor Heart Problem □ Multiple Sclerosis □ Neck Pain □ Neurological Problems □ Pacemaker □ Parkinson's
□ Polio □ Prostate Problems □ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain
□ Stroke/Heart Attack
□ Other: _____

List Type of **Medications** you are taking:

□ Anxiety □ Muscle Relaxors □ Pain Killers □ Insulin □ Birth control □ Cardiovascular □ Allergy □ Seizure
□ Cholesterol □ Other: _____

List your **Family History**:

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy □ Genetic Spinal Condition
□ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Parkinson's □ Polio
□ Prostate Problems □ Stroke/Heart Attack □ Other: _____

Please list all family members who had/has any of the problems above:

Example: Paternal Grandmother – High blood pressure

_____

Have you had any auto accident injuries, worker's compensation injuries, or other significant accidents? □ No □Yes

Describe: _____

If Female, are you pregnant? □ No □Yes How many weeks? _____

Have you ever smoked? □ No □Yes Do you smoke currently? □ No □Yes

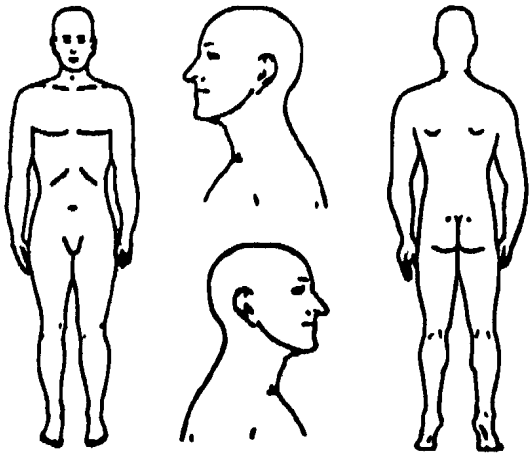
Do you drink alcohol? □ No □Yes - how many per day? _____

Do you drink caffeine? □ No □Yes - how many per day? _____

Do you exercise? □ No □Yes (what forms and how often): _____

Do you have good sleep habits? □ No □Yes

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- □ Become pain free
- □ Explanation of my condition
- □ Learn how to care for my condition
- □ Reduce symptoms
- □ Resume normal activity level

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO Is your pain on the □ Left □Right □ Both

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Achy □ Stiff □Sore

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain (0= no pain and 10= excruciating pain) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Pain Intensity: Minimum – Mild – Moderate – Severe – Unbearable

What makes your pain better (ice, heat, massage, etc)? _____

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

Is there anything else that we should know about your condition or your health? YES NO

_____

PATIENT'S SIGNATURE _____ DATE _____