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? _____

List any **Allergies**: _____

List any **Surgeries** and Date:_____

List **ALL Past Medical History** conditions:

☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain ☐ 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

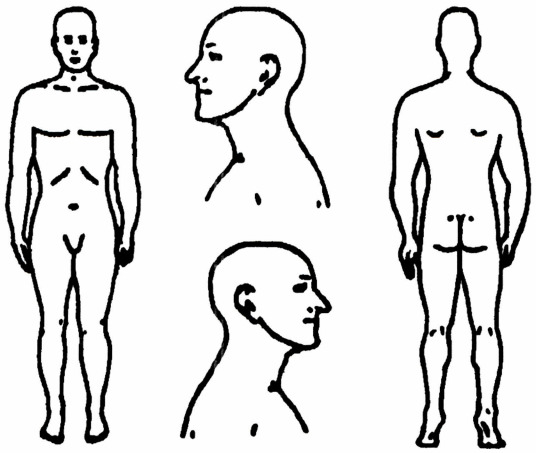
Do you drink alcohol? ☐ No ☐Yes - how many per day? _____

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 _____