

Patient Medical History
Back in Line Chiropractic Center

Name: _____ Date: _____

List any surgery(s) and dates: _____

List any falls or accidents: _____

Broken bones, dislocations or fractures: _____

Were you ever knocked unconscious? Yes No

Do you suffer from any condition(s) other than that for which you are consulting us? _____

Are you presently taking any medication, prescription or over the counter? _____

Do you have any allergies? _____

When did you last see a chiropractor? _____ Dr. _____

Please indicate conditions you have by marking below with (X), conditions you have had in the past with (O), and family history of conditions with (F):

- | | | | |
|------------------------------------|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Multiple Sclerosis |

PLEASE CHECK ALL PRESENT SYMPTOMS:

CARDIOVASCULAR

- general swelling
- loss of coordination
- swelling in face
- chest pain
- rapid heart beat
- blue or purple skin
- blue or purple nailbeds
- fainting
- ringing in ears
- heart attack
- high blood pressure
- irregular heart beat
- hardening of the arteries
- dizziness with nausea
- blurred vision
- fainting spells
- stroke
- diabetes
- cold hands and/or feet
- area of numbness
- arthritis of the neck
- previous neck or head injury
- loss of memory
- periods of blindness in one eye
- check if any of your family members have had a stroke

VERTEBROSILAR

- double vision
- pain across shoulders
- irregular muscle movement

MUSCULARSKELETAL SYSTEMS/HEAD

- unusually frequent headache
- unusually severe headache
- head feels heavy
- vertigo
- light-headedness
- loss of smell
- loss of taste
- loss of balance
- dizziness

NECK

- pain in neck
- neck pain with movement
- swelling in neck
- pinched nerve in neck
- neck out of place
- muscle spasms in neck
- grinding sounds in neck
- popping sounds in neck
- stiff neck
- limited neck movement

SHOULDERS

- pain in shoulders (right) (left)
- swelling in legs
- tension in shoulders
- muscle spasms in shoulder
- can't raise arm (right) (left)

ARM AND HANDS

- pain in upper arm
- pain in forearm
- pain in hands or fingers
- sensation of pins and needles in arms or fingers
- fingers fall asleep
- hands cold
- swollen joints in fingers
- sore joint in fingers
- loss of grip strength

MID BACK

- mid back pain
- pain between shoulder blades
- pain from front to back
- pain over kidney area
- muscle spasms in mid back

LOW BACK

low back pain
low back feels out of place
muscle spasms in low back

HIPS, LEGS, AND FEET

pain in buttocks
pain down leg
knee pain
leg cramps
pins and needles in legs
numbness in leg or toes
cold feet
swollen ankles or feet

SKIN HAIR NAIL

eczema
itchy skin
dry scalp
oily scalp
rough, scaly skin
dry skin
oily skin
psoriasis
yellow skin
bruise easily
paper thin nails
hair loss

EYES

blurring of vision
double vision
eyes fatigue easily
excessive tearing
lack of tearing
light bothers eyes
excessive itching
pain in eyeball

EARS

loss of hearing
pain in ears
discharge from ears
vertigo
ringing in ears

NOSE NASOPHARYNX

unusual nasal discharge
nose bleeds
pressure over eyes
pressure under eyes
obstruction in nose
frequent colds
sinusitis
nasal allergies
loss of sense of smell
any trauma to nose

MOUTH AND THROAT

cavities
pain in mouth
pain in throat
bleeding gums
difficulty swallowing
changes in voice

RESPIRATORY

shortness of breath
dry cough
productive cough
coughing up blood
wheezing

GASTROINTESTINAL

poor appetite
indigestion
can't eat some foods
nausea and vomiting
abdominal pain
change in bowel habits
diarrhea
constipation
hemorrhoids

WOMEN ONLY

painful period
spotting
vaginal discharge
premenstrual symptoms
irregular periods
lumps in breast
take birth control pills
of pregnancies: _____
of deliveries: _____

GENITOURINARY

urination
frequents
normal
infrequent
low
need to get up at night to urinate
abnormal intense desire to urinate
difficulty starting urination
decreased output
pain on urinating
dribbling
blood in urine
cloudy urine
lack of bladder control

VENERAL DISEASE

AIDS
syphilis
gonorrhea

SOCIAL HISTORY

smoking
other tobacco use
alcohol use
drink coffee or tea

diet is: balanced
 not balanced

rest is: sufficient
 not sufficient

recreation is: sufficient
 not sufficient

my stress level is: severe
 moderate
 minimal
 none

GENERALLY FEEL

nervousness
irritability
fatigue