Cark Chiropractic Clinic

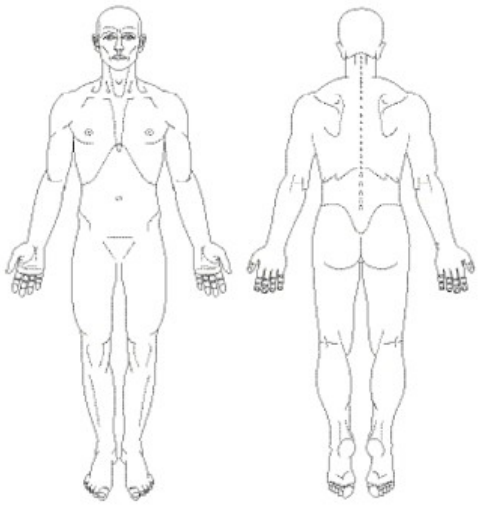
Chiropractic Patient History

Name_____ DOB _____

Have you ever received Chiropractic Care? Yes No If yes, when?_____

Chief Complaint: _____

Please mark location of pain on figures with an X.



PAIN Level: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme)

Please circle type of pain: dull aching sharp shooting burning throbbing deep nagging tingling/numb

Date Pain Began: _____

How did Pain Begin? _____

Does the pain radiate or travel (shoot)? Yes No

What aggravates the pain? _____

What relieves the pain? (medications/movements/ice/heat/etc…)

_____

Please fill out completely:

Medications	Vitamins	Allergies	Surgeries (Which/Date)	Broken Bones (Which/Date)	Smoking/ Nicotine	Alcohol
					Yes	Daily
					No	Weekly
					Quit	Occasionally

Health History: check all that apply

☐ Alcohol Abuse	☐ Heart Attack	☐ Prostate Cancer	FEMALES ONLY
☐ Anemia	☐ Heart Disease	☐ Rectal Cancer	☐ Age of first period
☐ Anxiety	☐ Hepatitis A / B / C	☐ Reflux/GERD	☐ Date of last period
☐ Arthritis	☐ High Blood Pressure	☐ Seizures	☐ Age of Menopause
☐ Asthma	☐ High Cholesterol	☐ Severe Allergies	☐ # of pregnancies
☐ Autoimmune Disease	☐ HIV	☐ STD/STI	☐ # of live births
☐ Birth Defects	☐ Hives	☐ Skin Cancer	☐ # of miscarriages
☐ Bladder Problems	☐ Hypertension	☐ Stroke	
☐ Bleeding Disease	☐ Kidney Disease	☐ Suicide Attempt	
☐ Bowel Disease	☐ Liver Cancer	☐ Thyroid Condition	
☐ Breast Cancer	☐ Liver Disease	☐ Ulcer	
☐ Bronchitis	☐ Lung Cancer	☐ Vision Impairment	☐ Other:_____
☐ Cervical Cancer	☐ Mental Disorder		
☐ Colon Cancer	☐ Migraines		
☐ Depression	☐ Osteoporosis		
☐ Diabetes	☐ Pneumonia		