



Name \_\_\_\_\_ Date \_\_\_\_\_

Please list any Doctor's you have seen in the last year or are seeing now \_\_\_\_\_

Have you been treated for any health conditions in the last year? \_\_\_\_Yes \_\_\_\_No If Yes, explain:

What prescriptions or over-the-counter medications are you taking?

Medication	Reason for Taking
_____	_____
_____	_____
_____	_____

Any car accidents, other accidents or falls: \_\_\_\_\_

Any ER or hospitalization \_\_\_\_\_

Any surgery: Appendectomy \_\_\_\_ Tonsillectomy \_\_\_\_ Gall Bladder \_\_\_\_ Hernia \_\_\_\_ Spinal \_\_\_\_\_

Other surgery or Broken Bones \_\_\_\_\_

Have you ever been treated by a Chiropractor? \_\_\_\_Yes \_\_\_\_No

Chiropractor's name and address \_\_\_\_\_

Reason for treatment \_\_\_\_\_

Date of last treatment \_\_\_\_\_ how long \_\_\_\_\_ how often \_\_\_\_\_ Did it help? Y N

Other Chiropractors seen \_\_\_\_\_

### Social and Occupational History

Level of education \_\_\_\_\_

Job description \_\_\_\_\_

Work schedule \_\_\_\_\_

Recreational activities \_\_\_\_\_

Lifestyle (level of exercise; alcohol, tobacco and drug use; diet) \_\_\_\_\_

### NOTE!

On the next page is a list of various symptoms, conditions, etc. Some may seem unrelated to the purpose of your appointment. However, these questions are important and must be answered carefully. Thank-you.

ON THE NEXT PAGE:

MARK ANY OF THE CONDITIONS OR PROBLEMS THAT YOU HAVE **NOW** WITH AN **"N"**

MARK ANY OF THE CONDITIONS YOU HAD IN THE **PAST** WITH A **"P"**

<u>MS</u>	<u>GI</u>	<u>__ Wheezing</u>
PAIN, NUMB or STIFF	<u>__ Diabetes</u>	<u>__ Asthma</u>
<u>__ Headache</u>	<u>__ Colonoscopy</u>	<u>__ Emphysema</u>
<u>__ Jaw , jaw clicking</u>	<u>__ Difficult chewing</u>	<u>__ Pleurisy</u>
<u>__ Neck</u>	<u>__ Clicking jaw</u>	<u>__ Pneumonia</u>
<u>__ Neck Disk Degeneration</u>	<u>__ Weight loss/gain</u>	<u>__ Whooping Cough</u>
<u>__ Neck Disk Herniation (slipped)</u>	<u>__ Thirsty often</u>	<u>__ Tuberculosis</u>
<u>__ Neck Disk Bulge</u>	<u>__ Colitis</u>	<u>EENT</u>
<u>__ Shoulder(s)</u>	<u>__ Colon Cancer</u>	<u>__ Allergies</u>
<u>__ Carpal Tunnel</u>	<u>__ Diverticulitis</u>	<u>__ Tonsillitis</u>
<u>__ Arms(s)</u>	<u>__ Constipation</u>	<u>__ Jaw Pain/Clicking</u>
<u>__ Elbow(s)</u>	<u>__ Diarrhea</u>	<u>__ Ear Ringing</u>
<u>__ Forearm(s)</u>	<u>__ Digestion trouble</u>	<u>__ Poor Hearing</u>
<u>__ Wrist(s)</u>	<u>__ Heartburn</u>	<u>__ Swollen Glands</u>
<u>__ Hand(s)</u>	<u>__ GERD/Acid Reflux</u>	<u>__ Poor Vision</u>
<u>__ Finger(s)</u>	<u>__ Stomach cramps</u>	<u>__ Eye Pain/Strain</u>
<u>__ Upper back</u>	<u>__ Appendicitis</u>	<u>__ Hay Fever</u>
<u>__ Between Shoulder Blades</u>	<u>__ Excessive hunger</u>	<u>__ Rheumatic Fever</u>
<u>__ Midback (below shoulder blades)</u>	<u>__ Gall Bladder pain</u>	<u>__ Scarlet Fever</u>
<u>__ Low back</u>	<u>__ Stuffed Nose</u>	<u>__ Diphtheria</u>
<u>__ LB Disk Degeneration</u>	<u>__ Nose Bleed</u>	<u>__ Typhoid Fever</u>
<u>__ LB Disk Herniation (slipped)</u>	<u>__ Sinus Infections</u>	<u>__ Polio</u>
<u>__ LB Disk Bulge</u>	<u>__ Sore Throat</u>	<u>__ Hiv/Aids</u>
<u>__ Sciatica</u>	<u>__ Dental Problems</u>	<u>__ Anemia</u>
<u>__ Buttock(s)</u>	<u>CV</u>	<u>__ Measles</u>
<u>__ Hip(s)</u>	<u>__ Heart Disease</u>	<u>__ Mumps</u>
<u>__ Upper Leg(s)</u>	<u>__ Heart Attack/Surgery</u>	<u>__ Small Pox</u>
<u>__ Knee(s)</u>	<u>__ Chest Pain</u>	<u>__ Chicken Pox</u>
<u>__ Lower Leg(s)</u>	<u>__ Poor Circulation</u>	<u>__ Cancer</u>
<u>__ Ankle(s)</u>	<u>__ Irregular Heartbeat</u>	<u>__ Goiter</u>
<u>__ Foot, Feet</u>	<u>__ Ankle Swelling</u>	<u>__ Influenza</u>
<u>__ Arthritis</u>	<u>__ Short Breath</u>	<u>__ Alcoholism/Drug Abuse</u>
<u>__ Bursitis</u>	<u>__ Varicose Veins</u>	
<u>__ Hernia</u>	<u>__ Clots in arteries</u>	<u>__ Sexually-transmitted disease</u>
<u>__ Scoliosis</u>	<u>__ High/Low Blood Pressure</u>	<u>__ Venereal Disease</u>
<u>__ Swollen Joints</u>	<u>GU</u>	
<u>__ Walking Problems</u>	<u>__ Bladder trouble</u>	<u>Females</u>
<u>__ Poor Posture</u>	<u>__ Blood in Urine</u>	<u>__ Hysterectomy/other surgery</u>
<u>NS</u>	<u>__ Frequent Urination</u>	<u>__ Menstrual Irregularity</u>
<u>__ Convulsions</u>	<u>__ Inability to Control Bladder</u>	<u>__ Menstrual Cramps</u>
<u>__ Paralysis</u>	<u>__ Kidney Infection / Stone</u>	<u>__ Menstrual Backache</u>
<u>__ Tremors</u>	<u>__ Painful Urination</u>	<u>__ Breast Pain/Lumps</u>
<u>__ Sweats</u>	<u>__ Diminished Urination</u>	<u>__ Mammography</u>
<u>__ Numbness</u>	<u>__ Discolored Urine</u>	<u>__ Vaginal Pain/Infection</u>
<u>__ Stroke</u>	<u>__ Jaundice</u>	<u>__ Pregnant or may be</u>
<u>__ Neuralgia</u>	<u>__ Liver Trouble</u>	<u>__ Post Menopause</u>
<u>__ Forgetfulness</u>	<u>__ Nausea</u>	<u>Males</u>
<u>__ Confusion</u>	<u>__ Stomach Pain</u>	<u>__ Swollen Prostate</u>
<u>__ Nervousness</u>	<u>__ Poor Appetite</u>	<u>__ Prostatic Cancer</u>
<u>__ Depression</u>	<u>__ Vomiting</u>	<u>__ Testicular Cancer</u>
<u>__ Antidepressant use</u>	<u>__ Vomiting Blood</u>	<u>__ Surgery</u>
<u>__ Fainting</u>	<u>__ Discolored stools</u>	
<u>__ Dizziness</u>	<u>RESP</u>	
<u>__ Fatigue</u>	<u>__ Smoke Cigarettes</u>	
<u>__ Loss of Sleep</u>	<u>__ Persistent Cough</u>	
<u>__ Epilepsy</u>	<u>__ Lung Cancer</u>	
<u>__ Multiple sclerosis</u>	<u>__ Hard to Breathe</u>	
<u>__ Cold/tingling arms, hands, fingers</u>	<u>__ Spitting up Blood</u>	
<u>__ Cold/tingling legs, feet, toes</u>	<u>__ Spitting up Phlegm</u>	

Name \_\_\_\_\_ Date \_\_\_\_\_

14. Please list any x-rays, MRIs, CT scans, bone density, bone scans that you have had:

Area of body	Type of Test	Where was it done?	When	Results/do you have the report

15. Family History

Relationship	Health Problem(s)- such as heart disease, diabetes, arthritis, osteoporosis, cancer etc.
Father	
Mother	
Brother	
Sister	

16. Is there anything else you wish to tell the Doctor? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

17. Please read and sign the following certification:

I certify that the information I have given on the preceding pages is true and complete. I have not withheld any information relative to my health or any condition, problem or symptom. I hereby authorize Eickhoff Chiropractic Family Wellness Center, its Doctors and Staff, to provide me with Chiropractic care in accordance with this State's statutes.

\_\_\_\_\_  
Patient's (Parent/Guardian) Signature

\_\_\_\_\_  
Date

THANK-YOU!

*Dr. Eickhoff*

FOR OFFICE USE

Severe trauma	Direct head trauma	History of stroke	Dysphasia
Lost consciousness	Dizzy-poor balance	Poor coordination	Fever
Nuchal rigidity	Persistent night pain	Night pain worse	Recent infection