Stepping Stone Chiropractic

Patient Health History

Patient Title: *(check one)* □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Prof. □ Rev.

First Name: _____Nick Name:_____
Last Name: _____ Middle Name: _____ Suffix: _____
Address: _____
City/State/ Zip Code: _____
Primary Phone: _____ Secondary Phone: _____
Mobile Phone: _____
E-Mail: _____

Contact Method *(check one)*
□ Primary Phone □ Secondary Phone □ Mobile Phone □ Home Email

It is acceptable to leave a message on an answering machine □ At Home □ At Work □ On Cell
It is acceptable to leave a message with another person □ At Home □ At Work □ On Cell

Date of Birth: _____/_____/_____ **Age_____ Gender:** □Male □Female □Unspecified

Marital Status *(check one)* □ Single □ Married □ Other **SSN: _____**

Employment Status *(check one)*

□ Employed □ FT Student □ PT Student □ Other □ Retired □ Self Employed

I clearly understand that all services rendered to me are charged directly to me and that I am responsible for payment if I am not eligible to receive a health care benefit through this practitioner, I also understand that if I suspend or terminate my care and treatment, any fees for my professional services rendered to will be immediately due and payable. I agree that unpaid account will go into collections and all reasonable fees will be paid by me.

Signature of Patient: _____ Date: _____

Do you currently smoke tobacco of any kind? □ Yes □ Former smoker (Date your quit: _____) □ Never been a smoker
If yes, how often do you smoke? □ Current every day smoker □ Current sometimes smoker
How many packs a day?

Current medications or nutritional supplements, <u>including frequency</u> and <u>dosage</u> if known. If there are no current medications, check here: □

	Start date		Start date
1)		5)	
2)		6)	
3)		7)	
4)		8)	

List any known allergies you have had to any medications.
If no allergies are known, check here: □
1) _____ 3) _____
2) _____ 4) _____

Has any doctor diagnosed you with hypertension presently? □ Yes □ No If yes, describe:
_____

Has any doctor diagnosed you diabetes presently? □ Yes □ No
If yes, what kind? □ Type I □ Type II
If yes, was your blood lab-work test for hemoglobin A1c > 9.0% □ Yes □ No □ Not sure
If yes, other comments regarding diabetes:
Have you had an X-ray, CT scan, or MRI of you low back spine in the past 28 days? □ Yes □ No
Have you had a bone scan done? □ Yes □ No
If yes, when? _____ Diagnosis: _____

Emergency Contact

Contact Name: _____
Relationship to Patient: _____
Contact Phone: (_____) _____-_____

How did you hear about us?

_____

If referred by another patient may we thank them for the Referral? □ Yes □ No

Medical Information

Health History/Medical Conditions: Have you had any of the following?

	Alcoholism		Emphysema		High Cholesterol		Prostate Problems
	Anemia		Epilepsy		Kidney Disease		Prosthesis
	Anorexia/Bulimia		Eye Condition		Liver Disease		Psychiatric Illness
	Arthritis		Fibromyalgia		Lupus		Scoliosis
	Asthma		Fractures		Lyme Disease		Skin Disorders
	Back/Neck Condi.		Gall Bladder Dis.		Miscarriage		Stroke
	Bleeding Disorder		Gout		Multiple Sclerosis		Thyroid Problems
	Breast Lump		Headaches		Neurological Cond.		Tuberculosis
	Cancer		Heart Disease		Osteoporosis		Ulcers
	Chemical Depend.		Hepatitis		Pacemaker		UTI
	Chicken Pox		Hernia		Parkinson's Disease		Venereal Disease
	Depression/Anxiety		Herniated Disk		Pinched Nerve		
	Diabetes		High Blood Pres.		Polio		

Family History: Please also indicate relationship

M=Mother F=Father S=Sister B=Brother GM=Grandmother GF=Grandfather

	Arthritis		Psychiatric
	Cancer		Stroke
	Cholesterol		Thyroid
	Diabetes		
	Heart Problems		
	High Blood Pressure		

Hospitalization History:
Dates: _____
Reason: _____
Name of Hospital: _____

Occupational History:
Job Description: _____
Activities related to it: _____

Physical Stress Level*:* *(circle one)* 1 being minimal 10 being extreme

1 2 3 4 5 6 7 8 9 10

Recreational History:

Exercise or Sport	Frequency	Current difficulty level (1-10)	Prior difficulty level (1-10)

Surgical History: Please note whether it was an **IN** Patient or **OUT** patient procedure, please describe in any available space.

	Abdominal/Gastrointestinal		Cardiovascular Procedure
	Joint Procedure		Prostate/Genitourinary
	Back Surgery		Neck Surgery
	Gynecological/Genitourinary		Skin Procedures

Social History:

Alcohol:	Never	Occasionally	Frequently	**Coffee:**	Never	Occasionally	Frequently			
Soda:	Never	Occasionally	Frequently	**Water:**	Never	Occasionally	Frequently			
Sleep disturbance:	Never	Occasionally	Frequently	**Pain Meds**:	Never	Occasionally	Frequently			
Rec. Drugs:	Never	Occasionally	Frequently	**Exercise:**	Never	Occasionally	Frequently			
Healthy Eating: *(circle one)*	1	2	3	4	5	6	7	8	9	10
Physical Stress Level *(circle one)*	1	2	3	4	5	6	7	8	9	10
Emotional Stress Level *(circle one)*	1	2	3	4	5	6	7	8	9	10

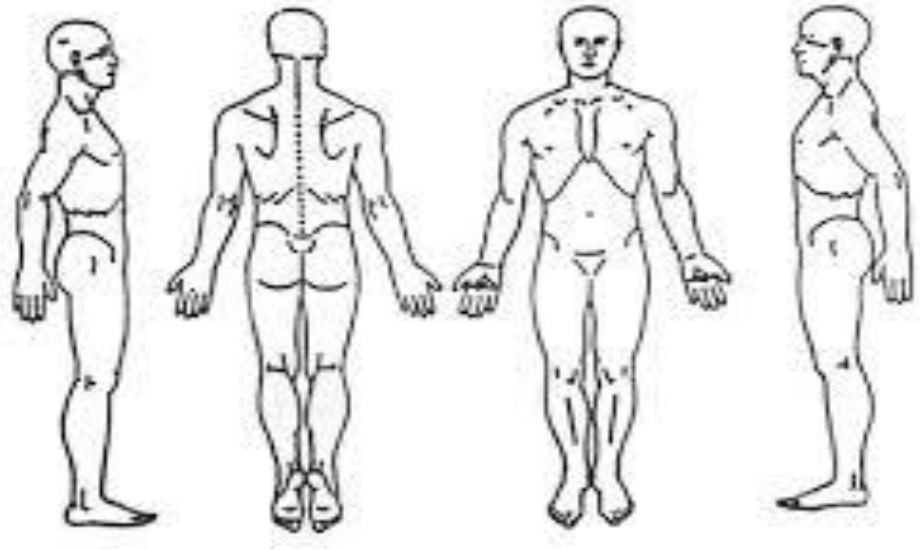
Major Stressors: _____

Daily Activities:

Sitting:	Never	Occasionally	Frequently	Standing:	Never	Occasionally	Frequently
Bending:	Never	Occasionally	Frequently	Walking:	Never	Occasionally	Frequently
Light Lifting:	Never	Occasionally	Frequently	Heavy Lifting:	Never	Occasionally	Frequently
Reaching:	Never	Occasionally	Frequently	Computer Use:	Never	Occasionally	Frequently
Overhead Work:	Never	Occasionally	Frequently	Operate Machinery:	Never	Occasionally	Frequently

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

=Numbness X =Burning / =Stabbing 0 =Pins & Needles + = Dull Ache



Describe your symptoms and any other main health problems:

_____

When did your symptoms start? Month_____ Day_____ Year_____

Is your condition due to an accident? _____ If yes, what was the date _____

Type of accident: *(circle one)* Auto Work Home Other_____

On average, how intense would you say your pain is? (0- none to 10 = unbearable) Circle one

0 1 2 3 4 5 6 7 8 9 10 N/A

Are there any radiating symptoms (numbness, tingling, and pain)? *(Circle one)*

Left Right Bilaterally Where? _____

Please indicate below how your pain is at different points of the day.

In the morning	Better	Worse	Same
By mid-day	Better	Worse	Same
Throughout the day	Better	Worse	Same
End of the day	Better	Worse	Same
Night while sleeping	Better	Worse	Same

What describes the nature of you symptoms? *(Circle all that apply)*

Dull	Sharp	Throbbing
Burning	Deep	Aching
Tingling	Stabbing	Cramping
Numbness	Radiating	Stiffness

Aggravating Factors: *(Circle all that apply)*

Sitting	Standing	Walking	Bending
Stooping	Lifting	Sleeping	Sneezing
Coughing	Straining	Reaching	Twisting
Looking Up	Looking Down	Movement	Rest
Lying on Back	Driving	Typing	Scooping
Lying on Stomach	Exercise	House Chores	Stair Stepping

Relieving Factors: *(Circle all that apply)*

Sitting	Standing	Lying	Knee's Bent Up
Support	No Movement	Movement	Heat
Ice	Analgesic Topical	Ibuprofen	Medication
Rest	Stretching/Exercise	Adjustments	

In general, would you say your overall health right now is? *(Circle one)*

Excellent	Very Good	Good	Fair	Poor

Who have you seen for your symptoms either in the past or present? *(Circle one)*

No One	Other Chiropractor	Medical Doctor	Physical Therapist

Other: _____

What treatments have you received for your symptoms? *(Circle all that apply)*

Adjustments	Physical Therapist	Medication	Surgery

Other: _____

When did you receive this treatment? *(Circle one)*

In the last month	2-3 months ago	3-6 months ago	6 months-1 year
1-2 years ago	2-5 years ago	5-10 years ago	10+ years ago

What test have you had for your symptoms? *(Circle all that apply)*

X-Ray	MRI	CT Scan	Other

When were these test done?

In the last month	2-3 months ago	3-6 months ago	6 months-1 year
1-2 years ago	2-5 years ago	5-10 years ago	10+ years ago

Have you had similar symptoms in the past? □Yes □No