

**PATIENT HISTORY**

**PLEASE PRINT**

**Date:** \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Telephone: (Hm) \_\_\_\_\_ (Wk) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email address: \_\_\_\_\_

Birth day: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Emergency Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employment: \_\_\_\_\_ Type of work: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Employment: \_\_\_\_\_

Payment Basis: Cash: \_\_\_\_\_ Check: \_\_\_\_\_ Visa /Master Card: \_\_\_\_\_

How did you hear about this office? \_\_\_\_\_

**PAST HEALTH HISTORY**

Medical Physician: \_\_\_\_\_ City: \_\_\_\_\_

Previous Chiropractic Care: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Name of Chiropractor: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Condition Treated: \_\_\_\_\_

**SURGERIES**

**Date(s)**

**Type of Surgery**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HISTORY OF ACCIDENTS**

**Date or Age**

**Type of Accident**

**Type of Injury**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DAILY HABITS** (SPECIFY AMOUNTS)

Sleep (hrs) \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Alcohol \_\_\_\_\_ Smoking \_\_\_\_\_ Diet Sodas \_\_\_\_\_

**ALLERGIES** (Type)

\_\_\_\_\_

**CURRENT HISTORY**

**NAME OF MEDICATION**

**PURPOSE**


**Have you had any of the following?** Arthritis \_\_\_\_ Heart Disease \_\_\_\_ Cancer \_\_\_\_ Diabetes \_\_\_\_  
Epilepsy \_\_\_\_ Alcoholism \_\_\_\_ Depression \_\_\_\_

**Comments on the above:** \_\_\_\_\_

**PLEASE CIRCLE ALL CURRENT SYMPTOMS:**

**Muscle/Joint**

**General**

**Gastrointestinal**

**Neck**

Pain  
Spasms  
Stiffness

Headaches  
Dizziness  
Fainting  
Sleep Loss  
Fatigue

Poor Appetite  
Poor Digestion  
Excess Hunger  
Belching/Gas  
Nausea  
Vomiting  
Abdominal Bloating  
Constipation  
Diarrhea

**Mid-back**

Pain  
Spasms  
Weakness  
Stiffness

Nervous  
Weight Loss  
Freq. Colds  
Sinus Infections

Colon Trouble  
Hemorrhoids  
Liver Trouble  
Gal Bladder  
Colitis  
Hiatal Hernia

**Low-back**

Pain  
Spasms  
Weakness  
Stiffness

**Cardio-Vascular**

Irregular Heart  
High Blood Pressure  
Chest Pain  
Ankle Swelling  
Poor Circulation  
Stroke  
Varicose Veins  
Anemia

**Genito-Uninary**

Frequent Urination  
Painful Urination  
Kidney Stones  
Prostate

**Pain**

Arms/Shoulders L / R  
Hands/Elbows L / R  
Hips/Legs/Knees L / R  
Feet/Ankles L / R

**Skin**

Rashes  
Itching  
Bruising  
Dryness  
Hives  
Slow Healing

**For Woman Only**

Pre-Menstrual Sympt.  
Excessive Flow  
Irregular Cycles  
Yeast Infections  
Breast Lumps  
Menopause

**Numbness**

Arms L/R  
Hands L/R  
Legs L/R  
Feet L/R

**Respiratory**

Chronic Cough  
Difficulty Breathing  
Asthma  
Emphysema

**Are you Pregnant?**

Yes: \_\_\_\_ No: \_\_\_\_

**Joint Swelling**  
**Spinal Curvature**  
**Tail Bone Pain**

I consent to needed or required chiropractic examinations, therapy, or chiropractic treatment necessary for my case after evaluation by the doctor. I UNDERSTAND THAT I AM PERSONALLY FINANCIALLY RESPONSIBLE FOR ALL SERVICES PERFORMED AT GREENER CHIROPRACTIC AT THE TIME SERVICES ARE RENDERED.

**Patient/Parental Signature:** \_\_\_\_\_