Nelson & Nelson CHIROPRACTIC

Sanford

PERSONAL HISTORY

Date _____ / _____ / _____

NAME:_____
First Middle Last

ADDRESS: _____ CITY _____ ST _____ ZIP _____

Home # (____) _____ - _____ Cell # (____) _____ - _____ Work # (____) _____ - _____

Employer: _____ Occupation: _____ How long employed? _____

Work Hours: **From** _____ **to** _____ **Lunch Break at:** _____ **Full-time / Part-time**

Emergency Contact: _____ Relationship: _____ Phone #: (____) _____ - _____

Age: _____ Date of Birth: ____ / ____ / ____ Sex: M / F Height: _____' _____" Weight _____ lbs

Single Married Divorced Widow Children No / Yes **How many children?** _____

Smoke: No / Yes **How long have you smoked?** _____ Alcohol: **Never Occasionally Daily**

Hobbies: No / Yes **Running Exercising Weightlifting Soccer Horseback Riding Other:** _____

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1) What is your concern today? _____

2) When did this current concern start? _____

3) How did this happen? **Car Accident Lifting Bending Fall Sports Injury Gradually**
Other: _____

4) Describe it: **Ache Dull Sore Stiff Cramp Sharp Stabbing**
Other description(s):_____

5) My issue is: Constant (**100%**) Frequent (**75%**) Occasional (**50%**) On / Off (**25%**)

6) Does anything make it better? **No / Yes Rest Ice Heat Massage Prescription Medication**
Over-the-counter Medication Chiropractic Adjustments Other: _____

7) Does anything make it worse? **No / Yes Bending Standing Walking Sitting Sit to Standing**
Lying on Back Lying on Side Other:_____

8) Have you seen someone **RECENTLY** and/or in the **PAST**? **No / Yes Hospital Urgent Care Family Doctor**
Orthopedic Neurologist Pain Management Pain Management Chiropractor
Physical Therapist Massage Therapist Acupuncture Other: _____

9) Did they perform any tests? **No / Yes X-Ray MRI CT Nerve test (EMG) Blood work Urine test**
Bone Test (DEXA scan) Ultrasound Other: _____

10) What was the treatment on your **RECENT** visit and/or in the **PAST**? **Prescription Medication**
Over-the-counter Medication Injection Chiropractic Adjustment Physical Therapy
Recommended Surgery Nothing Other: _____

11) Were you given a follow-up appointment? **No / Yes Did you go? No Yes Not yet**

12) **RECENT** and/or **PAST** diagnosis of your current issue? _____

13) Are you presently able to work? **No / Yes How many days of work have you missed?** _____

14) How often do you **SIT** at work? **Constantly Frequently Occasionally On/Off Not required**

15) How often do you **STAND** at work? **Constantly Frequently Occasionally On/Off Not required**

16) How often do you **LIFT** at work? **Constantly Frequently Occasionally On/Off Not required**

17) Have you **EVER** had any of today's problems before? **No / Yes**

If yes, when was the LAST episode that you remember? _____

18) How many Chiropractors have you seen in the past? **0 1 2 3 4 5**

When was your last chiropractic visit? _____ Name/Location:_____

19) Have you ever had Physical Therapy? **No / Yes If yes, for what: _____**

20) Do you have a family doctor? **No / Yes Name of doctor/office: _____**

Are they aware of this current issue? No / Yes Have they seen you for this? No / Yes

21) Have you ever been hospitalized? **No / Yes If YES, for what and when: _____**

22) Have you ever had surgery? **No / Yes If YES, what surgery and when: _____**

23) Have you ever broken a bone? **No / Yes If YES, what bone(s)? _____**

24) Have you ever been diagnosed with **CANCER**? **No / Yes If YES, when (date):_____**

If yes, type of cancer? _____ Do you currently see an oncologist? No / Yes

25) Do you currently have a **STENT, Pacemaker** and/or any other **implant device**? **No / Yes** _____

26) Do you have any **METAL implants** and/or **screws** in your body? **No / Yes Where?** _____

27) Have you ever had a **STROKE** and/or **HEART ATTACK**? **No / Yes When?** _____ **How many?**_____

28) Do you currently take **ANY** medication? **No / Yes Medications** _____

_____

29) Are you presently being treated for any other condition? **No / Yes Please circle below and/or add in:**

Anxiety	Fibromyalgia	Osteoporosis
Arthritis (Osteoarthritis)	Gout	Osteopenia
Aneurysm	Gallbladder	Ovary
Appendix	Gallstones	Ovarian Cyst
Adrenal Gland	G.E.R.D.	Open Heart Surgery
Brain	High Blood Pressure	Pancreas
Bladder	High Cholesterol	Prostate
Blood Clot	Heart Attack	Stroke
Cancer	Heart Issues	Stent
C.O.P.D.	Hyperthyroidism	Scoliosis
Constipation	Hypothyroidism	Spinal Stenosis
Cyst	Kidney	Stomach
Diabetes	Kidney Stones	Small Intestine
Depression	Liver	Spleen
Disc Bulge	Lung	Testicle
DDD/DJD	Large Intestine	Thymus
Endometriosis	Mouth	Tongue
Esophagus	Metal Implants	Thyroid
Ear	Multiple Sclerosis	Urinary Tract Infection
Eyes	Myasthenia Gravis	Uterus

Other:_____

_____

Women Only

30) Are you pregnant? **No / Yes Date of last Menstrual period?** _____

31) Have you been diagnosed with **Osteopenia** and/or **Osteoporosis**? **No / Yes**