VIENNA CHIROPRACTIC ASSOCIATES, P.C.
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PATIENT HISTORY AND APPLICATION
FOR
CHIROPRACTIC CARE

Date _____
Patient's Name _____
Home Address _____
City, State, Zip _____
Birth Date _____
Phone # _____

Social Security # _____
Referred By _____
Where Do You Work? _____
Occupation _____
Address _____
City, State, Zip _____
Phone # _____

If a minor, name and address of person responsible for care: _____

_____

I give permission for this minor to be seen at this office.

Signature _____ Relation to patient _____

What is the reason for today's visit? _____
_____
_____
_____

When did this problem start? _____
When did this incident begin? _____
Have you had this before? _____
If so, does today's problem feel any different? _____
Have you been out of work for the above? _____
When? _____
Full or Part Time? _____

Please give today's pain/problems a number, with "10" representing the most severe expression and "1" representing the most minimal.

1. _____
2. _____
3. _____
4. _____

Do any of the above problems interfere with the way you go about your day? _____
In what way? _____
_____
_____
_____
_____
_____
_____

Is this visit for injuries received during an auto accident or worker's compensation case? _____

If this case is still open, stop writing and go to the front desk for the appropriate forms. Without it, we cannot do any of the paperwork necessary to file your claim. The original paperwork must be completed before you are seen today.

Have you ever gone to a chiropractor before? _____
When was your last adjustment? _____
The techniques that worked best for me were: _____
_____

(OFFICE USE ONLY) _____
_____
_____
_____
_____

Patient Name _____

PERSONAL HEALTH HISTORY

Are you currently taking any medication (prescription or over the counter)? _____

If so, what? And why? _____

Have you ever had the following?

_____ heart disease	_____ seizures	_____ allergy
_____ gall bladder disease	_____ arthritis	_____ hypertension
_____ diabetes	_____ stroke	_____ ulcers
_____ cancer	_____ TB	_____ kidney disease
_____ headache	_____ asthma	_____ fainting

If you checked any of the above, please explain below: _____

_____

_____

_____

FAMILY HEALTH HISTORY

Age of: Mother _____
Father _____

Has anyone in the family ever had any of the following?

_____ heart disease			_____ arthritis
_____ hypertension (high blood pressure)			_____ gall bladder disease
_____ ulcers	_____ diabetes	_____ TB	_____ kidney disease
_____ cancer	_____ asthma	_____ fainting	_____ allergies
_____ epilepsy, seizures	_____ other		

If you checked any of the above, please explain below: _____

_____

_____

_____

When was your last physical examination? _____

Results? _____

_____

_____

(OFFICE USE ONLY) _____

_____

_____

_____

_____

GYNECOLOGICAL HISTORY

Onset of period _____ years Length _____ days Pain _____

Number of pregnancies _____ Number of children _____

Problems: _____

_____

_____

_____

_____

_____

Patient Name _____

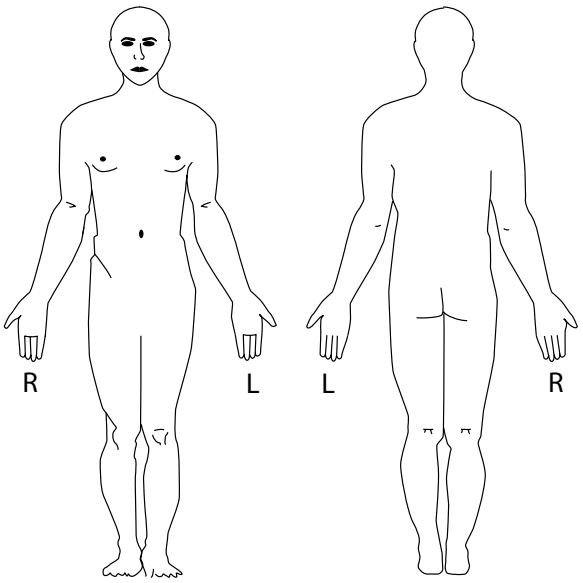
SURGICAL HISTORY
Describe any and all surgeries _____

TRAUMA
Describe any trauma (auto accidents, falls, blows, major sports injuries), regardless of age at the time, including care received: _____

Physical attacks/abuse: _____

Have you ever broken a bone? _____ Describe: _____

SYMPTOMS
Shade in areas of pain or abnormal sensation.



Do you ever have the following? (Check all that apply)

_____ neck pain[1]
_____ pain between shoulders[2]
_____ low back pain[3]
_____ weakness[4]
_____ poor balance[5]
_____ paralysis[6]
_____ colds[7]
_____ insomnia[8]
_____ stomach pain[9]
_____ poor appetite[10]
_____ bowel problems[11]
_____ urinary problems[12]
_____ general poor health[13]
_____ jaw pain[14]
_____ itching[15]
_____ ringing in the ears[16]
_____ knee Pain[17] __R __ L
_____ elbow Pain[18] __R __ L
_____ shoulder Pain[19] __R__L
_____ leg Pain[20] __R__L
_____ arm Pain[21] __R__L
_____ foot Pain[22] __R__L
_____ hand Pain[23] __R__L
_____ unexplained weight loss[24]
_____ nausea/vomiting[25]
_____ dizziness[26]
_____ shortness of breath[27]
_____ numbness or tingling[28]
Where? _____
_____ visual difficulty (excluding glasses)[29]
_____ hearing problems[30]
_____ difficulty swallowing[31]
_____ trouble taking a deep breath[32]
_____ difficulty speaking[33]

Explain any of the above you have checked: _____

Patient Name _____

My fears about my health or this visit are: _____

Have you seen any other health care provider this year? _____

At what time of the day do you feel your best? _____
At what time of the day do you feel your worst? _____

		How much?/How often?	What exercise do you get?
Do you:	_____ Smoke	_____	_____
	_____ drink	_____	_____
	_____ use drugs	_____	_____

Are you involved in any kind of counseling or self-improvement program? _____

What do you do to relax? _____

Do you suffer from any unexplained attacks of anxiety, fatigue, or depression? _____

Are you under any unusual stress right now? (friends, work, home, changes in life or environment)? _____

SIGNATURE: _____
DATE: _____

(OFFICE USE ONLY). _____