SPRINGFIELD
CHIROPRACTIC CENTER
A higher standard of healthcare

454 Morris Avenue
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www.springfield-chiropractic.com

CONFIDENTIAL HEALTH INFORMATION

Thank you for choosing the Springfield Chiropractic Center as your place for health and wellness.

First Name_____ Last Name _____

Street Address_____

City_____ State_____ Zip_____

Phone: Home _____ Cell _____ Work _____

May we contact you at work: Yes No Preferred Method of Contact *(circle all that apply)*: Home Cell Work All

Date of Birth_____ Age_____ Gender: M F **Circle one:** Single Married Divorced Widowed

Occupation_____ Type of work *(heavy lifting, computer, etc.)*_____

Name of: Spouse_____ Children (with ages)_____

Emergency Contact_____ Relationship_____ Phone_____

Family Physician (Primary Care Provider) _____

Referred to Our Office By_____

Reason(s) you are here today / Symptom(s) you are currently experiencing:

_____

Caused by: *(Circle one)* Auto Accident Injury Long term problem Unknown Other_____

Describe how the problem began:_____

_____

When did your symptoms first occur *(please provide a date)*:_____

Please rate your symptoms 0 (none) 2-3 (mild) 5 (moderate) 6-7 (intense) 8-9 (severe) 10 (unbearable) **Now:**_____ **At its worst**:_____

Describe your symptoms: *(circle all that apply)*

Sharp Dull Achy Burning Throbbing Stiffness Sore Stabbing Nagging

Numbness Tingling (pins and needles) Weak Cramps Other_____

How often to do you experience your symptoms: *(please circle one)*

Constant (75% to 100% of the time) Frequent (50% to 74% of the time) Occasional (25% to 49% of the time) Intermittent (24% or less)

Name:_____ **Date:**_____

Have you had this condition before *(if yes, when and what happened):*_____

_____

Do your symptoms travel to other parts of your body or occur with other symptoms? *(describe)*_____

_____

_____

Since your symptom(s) began is it: *(please circle one)* Getting better Getting worse Staying the same

Is there anything you are able to do to make you symptoms better: Yes *(please explain)* No

*(ex. Sitting, standing, heat, ice, medication):*_____

Is there anything that makes your symptoms worse: Yes *(please explain)* No

*(ex. Sitting, standing, walking, bending):*_____

Is there a time of day that your symptoms are worse: *(circle one)* Morning Afternoon Evening Bedtime All the time

Have you seen any other healthcare providers for this condition? *(circle all that apply)*

Medical Doctor Physical Therapist Massage Therapist Acupuncturist Chiropractor Other_____

*Name, date, describe treatment and result:*_____

*Name, date, describe treatment and result:*_____

*Name, date, describe treatment and result:*_____

List any diagnostic tests (with dates) you have had for this condition: *(x-ray, MRI, Blood tests, etc.)*_____

_____

Are you pregnant? *(circle one)* Yes *(how many weeks)*_____ No *(date of last period)*_____

List ALL medications and nutritional supplements you are currently taking:

Medication/Supplement	Dosage/Frequency	How long have you been taking	Reason for Use

Name:_____ **Date:**_____

Does your current condition affect you ability to: *(circle yes or no. If yes, describe how your condition affects you)*

Work Yes No *(describe)*:_____

Exercise Yes No *(describe)*:_____

Sleep Yes No *(describe):*_____

Care for yourself Yes No *(describe)*:_____

Do household chores Yes No *(describe)*:_____

Participate in hobbies/sports Yes No *(describe)*:_____

Please rate your current level of stress: *(circle one)* None Minimal Moderate High Burned out

Please list any other symptoms or conditions you are currently experiencing even if you feel they are not related to the reason for your visit to our office today:_____

_____

Review of Systems: *(circle all of the following you have had in the past or have now)*

Musculoskeletal

Neck pain Upper back pain Shoulder pain Pain between the shoulder blades Arm pain Hand pain Leg pain
Foot pain TMJ issues Hip pain Tight muscles General stiffness Swelling of joints Poor posture

Neurological

Headaches Migraines Dizziness Numbness Fainting Forgetfulness Pins and needles sensation
Confusion Depression Weakness Paralysis Convulsions Anxiety Difficulty concentrating
Cold Sensations Loss of bowel control Loss of bladder control Trouble walking Suicidal thoughts

Cardiovascular

Chest pain High blood pressure Irregular heart beat Palpitations High cholesterol Heart attack MVP Stroke

Respiratory

Chronic cough Difficulty breathing Asthma Wheezing Shortness of breath Sleep Apnea Sinus problems

Gastrointestinal

Lack of appetite Excessive thirst Frequent nausea Frequent vomiting Diarrhea Constipation Hemorrhoids Reflux
Food sensitivities Heartburn Abdominal pain Gall bladder problems Cramping Bloating after meals Black or bloody stools

EENT

Blurred vision Ringing in ears Hearing loss Chronic ear infections Loss of smell Loss of taste Sore throat
Double vision Loss of vision Hoarseness Chronic nasal infection Problems swallowing

Skin

Skin Cancer Psoriasis Eczema Acne Hair loss Rash New or changing moles Bruising

Endocrine

Thyroid issues Immune disorders Hypoglycemia Diabetes Hormonal problems Polycystic Ovarian Syndrome

Genitourinary

Kidney Stones Frequent urinary tract infection Prostate issues Sexual dysfunction PMS symptoms Menstrual problems
Difficulty urinating Unable to urinate Urine leakage Pelvic pain Urinary urgency Flank pain

General

Fatigue Irritable Difficulty sleeping Night sweats Unexplained weight loss Weight gain Chills

Name:_____ **Date:**_____

Past Health History

Illness: *(circle all illnesses you have had in the past or have now)*

AIDS/HIV	Chicken pox	Epilepsy	Diabetes	Glaucoma	Heart disease	Inflammatory Bowel Disease
Malaria	Measles	Mumps	Polio	Rheumatic fever	Scarlet fever	Multiple Sclerosis
Stroke	Tuberculosis	Endometriosis	Hepatitis	Crohn's	Ulcerative Colitis	Rheumatoid Arthritis
Uterine Fibroids	Gout	Osteoporosis	Osteopenia	Fibromyalgia	Celiac Disease	Parkinson's Disease
COPD	Osteoarthritis	Shingles	Ulcer	Typhoid fever	Other:_____	

Cancer: *(describe in detail)*_____

Surgery/Operations *(list ALL surgeries/operations and the date you had it)*:_____

Accidents/Injuries *(including broken bones, falls, car accidents, sporting injuries and the date(s) they occurred):*_____

Hospitalizations *(list All dates and reasons for hospital visit):*_____

Allergies *(list ALL allergies including medications, foods, supplements, etc.):*_____

Have you been to a chiropractor before? *(name(s), reason for going, and date(s)):*_____

Family History *(list All health conditions/diseases)*

Mother (age:_____):_____

Father (age:_____):_____

Sibling (Name:_____, age_____):_____

Sibling (Name:_____, age_____):_____

Sibling (Name:_____, age_____):_____

Social History *(describe in detail the amount of each)*

Alcohol use:	How much?_____	Coffee use:	How much?_____
Tobacco use:	How much?_____	Sugar/Soda:	How much?_____
Exercise:	How much?_____	Sleep:	How many hours per night?_____

Patient Signature:_____ **Date:**_____