FAMILY HEALTH HISTORY

Patient Name _____ Date _____

Please review the below listed symptoms and conditions and indicate those that are current health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply.

	Father Age____	**Mother** Age____	**Spouse** Age____	**Brother**(s) Age____ Age____		**Sister**(s) Age____ Age____		**Children** Age____ Age____ Age____		
First Name										
CONDITION										
Allergies										
Arthritis										
Auto Accidents										
Back Pain										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Epilepsy										
Frequent Colds/Flus										
Headache										
Heartburn										
Heart Trouble										
High Blood Pressure										
Low Energy										
Migraine										
Neck Pain										
Nervousness										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Sleeping Problems										
Other:										
Other:										
Other:										

Functional Rating Index

For use with Neck and/or Back Problems only.
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____ _____
Signature Date

NEW PATIENT INTAKE

Today's Date: _____

Name: _____ Nickname: _____

Address: _____ City _____ State _____ Zip_____

Social Security #: _____ Gender: Male Female

Home Phone: _____ Work: _____ Cell: _____

Race/Ethnicity: _____ Date of Birth: _____ Age: _____

Marital Status: _____ Spouse's Name: _____ Spouse's Phone: _____

We use text messaging for appointment reminders, who is your cell phone company? _____

Email Address: _____ Occupation: _____

Employers Name & Address: _____

Have you ever seen a Chiropractor before? Yes No If yes, when? _____

Whom may we thank for referring you to our office? _____

YOUR HEALTH SUMMARY

Please check all the symptoms you have had, even if they do not seem related to your current problem.

- ☐ Headaches
- ☐ Neck Pain
- ☐ Neck Stiff
- ☐ Numbness Upper Body
- ☐ Cold hands
- ☐ Pins & Needles Arms
- ☐ Ringing/Buzzing in ears
- ☐ Lights bother eyes
- ☐ Loss of balance
- ☐ Back Pain
- ☐ Numbness Lower Body
- ☐ Pins & Needles Legs
- ☐ Problems Urinating
- ☐ Frequent Urination
- ☐ Constipation
- ☐ Cold feet
- ☐ Menstrual Problems
- ☐ Hot flashes
- ☐ Nervousness
- ☐ Dizziness
- ☐ Tension
- ☐ Irritability
- ☐ Depression
- ☐ Fatigue
- ☐ Heartburn
- ☐ Fainting
- ☐ Fever
- ☐ Loss of taste
- ☐ Loss of smell
- ☐ Stomach upset
- ☐ Ulcers
- ☐ Sleeping problems
- ☐ Diarrhea
- ☐ Cold sweats
- ☐ Mood swings
- ☐ Pregnant? Y N Maybe?

Other Complaints: _____

_____

List any medications you are taking: _____

_____

Smoking Status: daily / occasionally / former / never

This office conforms to the current HIPPA guidelines. You may request a copy of our HIPPA policy at the front desk. Please initial to indicate that you have been made aware of its availability: _____

Patients Signature: _____ Date: _____

Guardian Signature: _____ Date: _____