Harchak Chiropractic Clinic LLC

MEDICAL *and* HEALTH HISTORY

Date _____ Patient Name _____ Date of Birth_____

MAIN PROBLEM

What pain causes you to come to the office? _____

What caused this pain?_____

When did this pain start?_____

How long does this pain usually last?_____

How bad is this pain? (Circle one - 1= mild pain - 10= intense pain) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain:

Cramping ☐ Aching ☐ Dull ☐ Sharp ☐ Shooting ☐ Bright ☐ Diffuse ☐

Lightening-like ☐ Throbbing ☐ Nagging ☐ Burning ☐ Deep ☐ Stinging ☐ Pressure-like ☐

How often does the pain occur? (Circle one) Occasional Frequent Constant

Does this pain travel to any other area?_____

What makes this pain better?_____

What makes this pain worse?_____

Are there other symptoms that occur with the pain? Stiffness, weakness, cramping-muscle spasms, swelling, other _____

What else have you done to treat this pain? Ice packs ☐ Heating pads ☐ Hot showers ☐ Rest ☐ Over the Counter pain meds. ☐ Other:_____

OTHER PROBLEM

Do you have another problem or other pain? _____

What caused this pain/problem?_____

When did this pain/problems start?_____

How long does this pain last?_____

How bad is this pain? (Select one - 1= mild pain - 10= intense pain) **1 2 3 4 5 6 7 8 9 10**

Select the word or words that best describe the pain:

Cramping ☐ Aching ☐ Dull ☐ Sharp ☐ Shooting ☐ Bright ☐ Diffuse ☐

Lightening-like ☐ Throbbing ☐ Nagging ☐ Burning Deep ☐ Stinging ☐ Pressure-like ☐

How often does the pain/problem occur? (Select one) Occasional ☐ Frequent ☐ Constant ☐

Does this pain travel to any other area?_____

What makes this pain better? _____

What makes this pain worse? _____

What else have you done to treat this pain? Ice packs Heating pads Hot showers Rest Over the Counter pain meds. Other: _____

Are there other problems you would like to discuss today? _____

OTHER HISTORY

Do you smoke? Yes ◯ No ◯ If yes, how many per day?_ _____

Do you drink? Yes ◯ No ◯ If yes, how much?_____

Do you exercise regularly? Yes ◯ No ◯ If yes, how often? _____

Are you pregnant? Yes ◯ No ◯ Date of last physical exam_____

Are you employed ? Yes ◯ No ◯ Where_____

How would you rate your daily amount of stress? (*select one*) Low/None ☐ Moderate ☐ High ☐ Extremely High ☐

Do you have children? No ◯ Yes ◯ If yes how many? _____ Youngest age is: _____ # at home _____

Are you married? Yes ◯ No ◯ Status: Never ☐ Separated ☐ Divorced ☐ Spouse ☐ Deceased ☐

How is your overall health? _____

List past illnesses_____

_____

Does your family have serious medical problems that appear to be inherited, i.e. "that run in your family?"

No ◯ Yes ◯ *describe:* _____

Surgeries / Hospitalizations / Injuries _____

_____

Medications - Purpose

_____

_____

(*Use other side if necessary*)

PRIVACY PROTECTION:

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: plan, coordinate and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third party payors; Conduct normal healthcare operations such as quality assessments and accreditation.

x _____ Date _____

Signature of patient or person acting on patient's behalf