In-Touch Chiropractic
Patient History

(**Please print**, all information is confidential)

Name: _____ Referred By: _____

Address: _____ City: _____ Prov.:____ P.Code: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Other Ph: _____ E-Mail: _____

Sex: M F T Marital Status: _____ Birthdate: _____ # of Children: _____

Occupation: _____ Employer: _____

Do you have extended insurance coverage? Y N

FOR PRESENT CONDITIONS MARK AN 'X', FOR PAST CONDITIONS MARK AN 'O'

MUSCLE & JOINT
- ____ Neck Pain
- ____ Mid Back Pain
- ____ Low Back Pain
- ____ Shoulder Pain
- ____ Hernia
- ____ Spinal Curvature
- ____ Faulty Posture
- ____ Arthritis
- ____ Headaches

STRESS SYMPTOMS
- ____ Headaches
- ____ Dizziness
- ____ Numbness in hands/feet
- ____ Ringing in Ears
- ____ Blurring of Vision
- ____ Loss of Sleep
- ____ Loss of Concentration
- ____ Loss of Memory
- ____ Irritable/Nervousness
- ____ Depression
- ____ Low Energy/Fatigue

GENERAL
- ____ Fever/Chills/Sweat
- ____ Fainting
- ____ Convulsions
- ____ Allergies
- ____ Skin Problems
- ____ Colds
- ____ Tremors
- ____ Diabetes
- ____ Cancer
- ____ Thyroid Trouble
- ____ Polio
- ____ HIV

EYES/EARS/NOSE/THROAT
- ____ Deafness
- ____ Ear Aches
- ____ Sore Throat
- ____ Asthma
- ____ Tonsilitis
- ____ Sinus Trouble

GASTROINTESTINAL
- ____ Difficult Digestion
- ____ Belching or Gas
- ____ Nausea or Vomiting
- ____ Pain Over Stomach
- ____ Constipation
- ____ Colon Trouble
- ____ Liver Trouble
- ____ Gall Bladder Trouble
- ____ Heartburn
- ____ Diarrhea
- ____ Bloody Stools

URINARY
- ____ Painful Urination
- ____ Waking to Urinate
- ____ Blood in Urine
- ____ Increased Urination

RESPIRTORY
- ____ Chronic Cough
- ____ Spitting Blood
- ____ Chest Pain
- ____ Pneumonia
- ____ Tuberculosis

CARDIOVASCULAR
- ____ Rapid Heart Beat
- ____ Slow Heart Beat
- ____ High Blood Pressure
- ____ Low Blood Pressure
- ____ Pain Over Heart
- ____ Swelling Over Ankles
- ____ Heart Disease

Prev. Heart Attacks? Y N

Poor Circulation? Y N

- ____ Painful Menstruation
- ____ Excessive Flow
- ____ Irregular
- ____ Cramps/ Backache
- ____ Abnormnal Discharge

Passed Menopause? Y N

Birth Control? Y N

Prev. Miscarriages? Y N

Are you pregnant? Y N

Not Sure

Due Date: _____

List all surgeries: _____

_____

What medications, even non-prescription, are you taking? _____

_____

Is your visit due to an accident, injury or trauma? Y N If so, was it AUTO _____ WORK _____

Briefly describe the events of the accident: _____

_____

Have you seen any other health care providers for this accident, injury or trauma? Y N Who? _____

What treatment did you receive? _____

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. If you require more space, use the reverse side of this form.

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