PHOENIXVILLE CHIROPRACTIC
1220 Valley Forge Road, Suite 5
Phoenixville, PA 19403

Title: Miss / Mr / Mrs / Ms / Dr

First name: ____ **Last Name**: ____

Date of Birth: __________________________________ **Gender**: Male / Female / Unspecified / Decline

___Left Handed ___Right Handed

Women Only: Are you pregnant? YES / NO

Marital Status: Single Married Separated Divorced Widowed

Address: ____ **Apt #**: __________

City: ____ **State**: ____________ **Zip Code**: ___________________

Phone #: ____ **Email**: ____

I am: Employed Unemployed Student Retired

Employer: ____ **Occupation**: ____

Emergency Contact: ____ Spouse / Auth. Rep / Guardian / Parent / Other

Contact Phone #: ____

Primary Care Doctor: ______________________________________ **Phone Number** : ____________________________________

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Name: ____ Date: ________________

Chief complaint/location: ____

What caused it: ____

Date of onset: ____________________________

Is this the result of a motor vehicle accident or work related injury? YES/NO

On a scale of 0 to 10 with 0 representing no pain & 10 being the most severe pain imaginable, please rate your pain.

0=None	*1=Minimal*	*2=Very mild*	*3=Mild*	*4=Mild to Moderate*	*5=Moderate*
6=Moderate to Severe	*7=Mildly Severe, Restricts some activity*	*8=Severe*	*9=Very Severe*	*10=Excruciating*	

How would you best describe the sensation of the pain/symptom: (circle all that apply)

Sharp	*Stabbing*	*Aching*	*Numbness/Lack of feeling*	*Deep*
Burning	*Dull*	*Tingling/Pins & Needles*	*Throbbing*	*Cramping*

If the pain radiates/travels, where? ____

What aggravates the pain/symptoms? (circle all that apply)

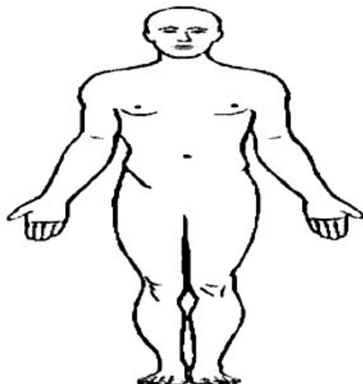
Sneezing	*Lifting*	*Exercising*	*Looking Up/Down*	*Walking*	*Coughing*
Sitting	*Stooping*	*Reaching*	*Standing*	*Sleeping*	*Driving*
Movement	*Bending*	*Rest*	*Straining*	*Climbing Stairs*	*Twisting*
Household Chores	*Typing*	*Scooping*	*Lying Face Down*	*Lying on Back*	*Changing Positions*

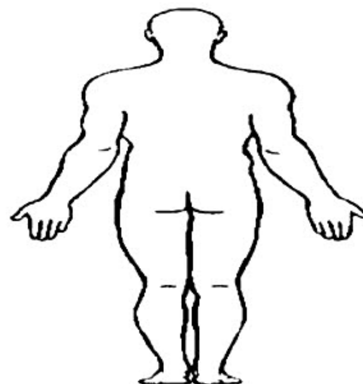
What relieves the pain/symptoms? (circle all that apply)

Sitting	*Standing*	*Lying*	*Knees Bent Up*	*Support*
No Movement	*Movement*	*Heat*	*Ice*	*Topical Analgesic*
NSAIDS(Tylenol, Motrin, Advil, Aleve)	*Pain Medication*	*Rest*	*Stretching/Exercise*	

Over the past weeks/months this complaint is: ___Improving ___Getting worse ___About the same

Have you seen anyone for this condition? YES/NO Whom? ______________________________





Musculoskeletal	Have	Had	No
Osteoporosis			
Arthritis			
Scoliosis			
Neck Pain			
Back problems			
Hip problems			
Knee Problems			
Foot/Ankle Problems			
Shoulder Problems			
Elbow/Wrist Problems			
TMJ Problems			
Poor Posture			
Muscle Pain			
Muscle Weakness			
Muscle Cramps			
Joint Stiffness			
Joint Swelling			
Lumps/Masses			
Genitourinary	***Have***	***Had***	***No***
Kidney Stones			
Infertility			
Bed Wetting			
Prostate Problems			
Erectile Dysfunction			
PMS Symptoms			
Skin	***Have***	***Had***	***No***
Skin Cancer			
Psoriasis			
Eczema			
Acne			
Hair Loss			
Rash			

Cardiovascular	Have	Had	No
High/Low BP			
Heart Attack			
High Cholesterol			
Poor Circulation			
Angina			
Bruising			
Digestive	***Have***	***Had***	***No***
Anorexia/Bulemia			
Ulcer			
Food Sensitivities			
Heartburn/Indigestion			
Constipation			
Diarrhea			
Sensory	***Have***	***Had***	***No***
Blurred Vision			
Ringing in the Ears			
Hearing Loss			
Chronic Ear Infections			
Loss of Smell			
Loss of Taste			
Endocrine	***Have***	***Had***	***No***
Thyroid Problems			
Immune Disorder(s)			
Frequent Infection			
Swollen Glands			
Low Energy			
Diabetes			

Neurological	Have	Had	No
Anxiety			
Depression			
Headache			
Dizziness			
Pins & Needles			
Loss of Sensation			
Stroke			
Memory Loss			
Seizures			
Tremors			
Loss of Coordination			
Paralysis			
Difficulty with Speech			
Respiratory	***Have***	***Had***	***No***
Asthma			
Apnea			
Emphysema			
Hay Fever			
Shortness of Breath			
Pneumonia			
Constitutional	***Have***	***Had***	***No***
Fainting			
Low Libido			
Poor Appetite			
Fatigue			
Weight Loss/Gain			
Weakness			
Fever			
Chills/Night Sweats			
Nervousness			
Concentration Loss			
Irritability			
Cancer			

Please list all past surgeries, injuries, traumas and accidents and the year they occurred.

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To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my complaints and health concerns.

____ ____________________

Signature Date

Patient history obtained from: Patient/Father/Mother/Son/Daughter/Spouse/Other