Ribley Family Chiropractic **Personal Health History**

Date:________Patient Name: ____Date of Birth:______________Age:___

History

Reason for coming in:____

____

Is condition: ❑Job Related ❑Auto Accident ❑Fall ❑Home Injury ❑Other_______________

When did this condition/pain begin?____

Is the condition/pain reoccurring? ❑No ❑YES How often?______________________________

Have you been seen before for this condition/pain? ❑No ❑YES

If Yes, by ❑Physician ❑Doctor of Chiropractic ❑Physical Therapist ❑Other_______________

What did they do/or recommend?____

Have you ever had previous chiropractic care? ❑No ❑YES When was your last visit?______________

What was the reason for your initial visit?____

How often did you go?__________________________ How long were you under care?________________

Why did you discontinue care?____

Women Only Are you pregnant? ❑**Yes** ❑**No**

If yes, due date______/_____/______ **If no**, date of last menstrual cycle__________/_____/______

Medications

Are you taking any medications? ❑No ❑YES If yes, list and describe (how long, over the counter, prescription)

____

____

What side effects (if any) have you experienced from these drugs?_____________________________

____

Injuries/Major Surgery/Operations- Please check any that apply

❑Appendectomy ❑Tonsillectomy ❑Gall Bladder ❑Hernia ❑Spinal ❑Hysterectomy ❑ Broken Bones

❑ Other: ____

Accidents/Falls History (such as auto/work/sport-related/jolts/trauma/etc.): ***IMPORTANT INFORMATION…***

All events which could have any impact upon the spine are of high significance to determine spinal health history. Please fill out completely.

Within the past year - when:_________Describe event:_______________________________________

Over a year ago - when:____________Describe event:_______________________________________

Childhood - when:________________Describe event:_______________________________________

Hospitalizations (other than above):____

Please check which applies to you?

Do you purchase: **Bottled Drinking Water**: ❑No ❑ Yes **Vitamins** ❑No ❑ Yes

Health Food Products (organic products, etc.): ❑No ❑ Yes **Probiotics** ❑No ❑ Yes

Are you a member of a gym or health club: ❑No ❑ Yes

Exercise: ❑None ❑Moderate ❑Daily ❑Heavy

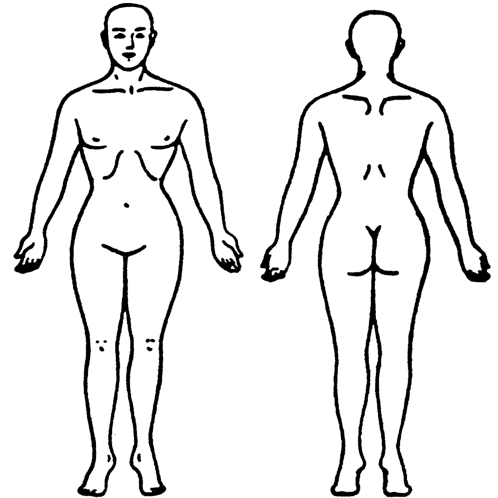
Do you: ❑**Consume artificial sweeteners Type:**___________________ ❑**Consume Dairy Products**

❑**Smoke**: Packs/Day____________ ❑**Alcohol:** Drinks/Week_____________ ❑**Coffee/Caffeine Drinks**: Cups/Day________

High Stress Level: ❑No ❑ Yes ❑Reason____

Type of pain:

❑ Dull ❑ Sharp ❑Burning ❑ Throbbing ❑ Numbness
❑ Stabbing ❑Tingling ❑ Cramps ❑ Stiffness ❑ Swelling
❑ Other ____



Pain radiating into extremities?________________________________

Rate the severity of your pain on a scale from:

1 (least pain) to 10 (severe pain):________________________________

Severity of pain:

❑ Mild (annoyance, no impairment) ❑ Slight (some mild impairment)
❑ Moderate (marked impairment) ❑ Severe (incapacitated/bedridden)

Mark an X on the picture where you have pain, numbness, or tingling

Duration of pain:

❑Intermittent (25% of the time) ❑Occasional (25%-50% of the time)

❑Frequent (50%-75% of the time) ❑Constant (76%-100% of the time)
❑Other ____

Check Symptoms You Have Noticed:

General	Gastrointestinal	Eye/Ear/Nose & Throat	Neck	Mid Back
❑Headaches ❑Shooting head pain ❑Loss of memory ❑Fatigue ❑Depression ❑Dizziness ❑Thyroid trouble ❑Chills ❑Sweats ❑Sleeping problems ❑Seizures ❑Fainting ❑Irritability ❑Nerves/ nervousness ❑Inner tension ❑Weight gain ❑Weight loss ❑Twitching of face ❑Facial pain ❑Jaw pain (TMJ) ❑Menstrual cramps/pain ❑Menstrual irregularity ❑Loss of balance ❑Prostate trouble ❑Cancer ❑Shortness of breath ❑Hernia ❑Arthritis ❑Diabetes ❑Painful joints ❑Swollen joints ❑Ulcers	❑Bowel changes ❑Intestinal gas ❑Constipation ❑Indigestion ❑Nausea ❑Stomach pain ❑Stomach trouble ❑Vomiting blood ❑Vomiting ❑Gall bladder trouble **Cardiovascular** ❑Chest pain ❑Heart attacks ❑Stroke ❑Low blood pressure ❑High blood pressure ❑Poor circulation ❑Irregular heart beat ❑Rapid heart beat ❑Swollen ankles ❑Cold feet ❑Anemia **Urinary:** ❑Bed wetting ❑Blood in urine ❑Frequent urination ❑Lack of bladder control ❑Painful urination ❑Kidney trouble	❑Sinus trouble ❑Loss of smell ❑Allergies ❑Hayfever ❑Asthma ❑Loss of taste ❑Inflammation of throat ❑Earache ❑Hoarseness ❑Loss of hearing ❑Persistent cough ❑Ringing in ears ❑Blurred vision ❑Vision- flashes/halos ❑Tonsillitis ❑Lights bother eyes **Skin** ❑Bruise easily ❑Hives ❑Itching ❑Change in moles ❑Rash ❑Sores that won't heal	❑Neck pain ❑Grinding/popping in neck ❑Neck stiffness ❑Pinched nerve in neck ❑Neck feels out of place ❑Muscle spasms in neck **Shoulders** ❑Shoulder/arm tightness ❑Shoulder/arm pain ❑Pain in shoulder joint ❑Pain across shoulders ❑Can't raise arms ❑Tension in shoulders ❑Pinched nerve in shoulders **Arms & Hands** ❑Pins & needles in arms ❑Pins & needles in hands ❑Numbness in arms/hands ❑Pain in upper arm ❑Pain in elbow ❑Pain in forearm ❑Pain in hand ❑Pain in fingers ❑Weakness of hand ❑Cold hands	❑Mid-back pain ❑Spinal curvature ❑Mid-Back stiffness ❑Pain between shoulder blades ❑Pain from front to back ❑Muscle spasms in Mid–Back **Low Back** ❑Low back pain ❑Low back stiffness ❑Low back weakness ❑Low back feels out of place ❑Muscle spasms in low back **Hips, Legs, & Feet** ❑Cold feet ❑Pain in buttocks ❑Pain in hip joint ❑Pain down leg ❑Pain in knee ❑Pain in ankle ❑Pain in foot ❑Weakness of leg ❑Weakness of knee ❑Leg cramps ❑Pins & needles in legs

Symptoms Other Than Above ____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or ant members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.
Patient Signature____Date____________________

(If under age 18)Parent's Signature____________________________________Date____________________