**Lifetime Wellness Chiropractic** Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History Form** (For educational purposes only, never sold

or released to anyone.)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M \_\_\_\_ F\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Married Single Divorced Widowed

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: (Name and Phone #) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Who may we THANK for referring you to us?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries:** (Circle all that apply and approximate date of surgery)

None Gallbladder Hernia Dental

Appendix Elbow Neck Tonsillectomy

Back Gynecological Low Back Brain/Tumor

Disc Heart Obstetrical Carpal Tunnel

EENT Gastrointestinal Shoulder Other: \_\_\_\_\_\_\_\_\_\_

Chest Hip Wrist Other: \_\_\_\_\_\_\_\_\_\_

Foot Knee Neurological Other: \_\_\_\_\_\_\_\_\_\_

**Past Medical History:** (Circle all that apply)

None Epilepsy Joint Stiffness Prostate Problems

Ankle Pain Eye/Vision Problems Knee Pain Shoulder Pain

Arm Pain Fainting Leg Pain Stroke/Heart Attack

Arthritis Fatigue Low Back Pain Spinal Cord Injury

Asthma Foot Pain Menstrual Troubles Sprain/Strain

Back Pain Hand Pain Mid Back Pain Ulcers

Broken Bones Genetic Spinal Disorder Minor Heart Trouble Stomach Problems

Cancer Headaches Multiple Sclerosis Tumor

Chest Pain Hearing Problems Neck Pain Wrist Pain

Diabetes Hepatitis Polio Other: \_\_\_\_\_\_\_\_\_\_

Dizziness High Blood Pressure Pacemaker Other: \_\_\_\_\_\_\_\_\_\_

Depression/Anxiety Hip Pain Parkinson’s Disease

Elbow Pain Jaw Pain Significant Weight Change

**Medications:** (Name of drug, dose and why you are taking it)

Medication Dose Reason for Taking

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Lifetime Wellness- History-Page 2**

**Family History**: (Indicate if alive or deceased and if there is a major health concern; i.e., heart

disease, cancer, stroke, diabetes, etc.)

(Alive/Deceased) Health Condition

Mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Son(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daughter(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sibling(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grandfather(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grandmother(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Accidents:** Falls, car accidents, etc. (Provides details and dates to the best of your ability)

**Do you have any allergies?** (List your allergies) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer the following questions by circling **Yes** or **No**

Do you smoke or use tobacco? Y N Do you have good sleep habits? Y N

Do you use drugs? Y N Do you have good health? Y N

Do you drink alcohol? Y N Do you have an STD history? Y N

Do you work/Employed? Y N Do you have work stress? Y N

Do you use caffeine? Y N Do you have home stress? Y N

Do you have poor diet habits? Y N Do you have other stress? Y N

Do you have a disability? Y N Are you married? Y N

Do you exercise regularly? Y N Are you single? Y N

Do you have a normal family environment? Y N Are you in college? Y N

Are you in high school? Y N

**What are your complaints?** (Please let us know if this is car accident or work related)

Neck Jaw Hip

Headaches Shoulder Leg

Upper Back Arm Knee

Mid Back Elbow Ankle

Low Back Wrist Foot

Routine Care Hand Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When did the symptoms begin?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unsure\_\_\_\_\_\_\_\_\_\_\_\_

**Describe how the symptoms began:** (Write in space provided or write unsure)

**Lifetime Wellness-History-Page 3**

**Is pain on the:** Right Left Both

**How are the symptoms changing:** Better Same Worse

**Have you had similar symptoms in the past?** Yes No

**The symptoms are:** Constant (76%-100%) Frequent (51%-75%)

Occasional (26%-50%) Intermittent (0-25%)

**Describe the nature of the symptoms:** (Circle all that apply)

Burning Stabbing Radiating Throbbing

Numbness Tingling Shooting Other: \_\_\_\_\_\_\_\_\_\_

Sharp Dull aching Tightness Other: \_\_\_\_\_\_\_\_\_\_

**Rate new symptoms on a scale from 0-10:**  (0=No Pain, 10=Excruciating) \_\_\_\_\_\_\_

**How do your symptoms affect your ability to perform daily activities such as working or driving?** (0=No affect, 10=No possible activity) Rate 0-10 \_\_\_\_\_\_

**What makes your pain better?**  (Circle all that apply)

Acupuncture Stretching Therapy Sleep/Rest

Ice Chiropractic Physical Therapy Nothing

Pain Meds Massage Heat Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**What activities make pain worse?** (Circle all that apply)

Baking Standing Reading Lying Down

Bending arm Using a phone Sewing Mowing

Caring for children Working Sitting Running

Concentrating Bathing Turning Pushing/pulling with hands

Doctor’s visits Bending leg Walking Sexual activity

Dressing Carrying objects Yard work Speaking

Exercise/Sports Cooking/cleaning Bending Twisting

General mobility Doing hobbies Care of others/pets Watching TV

Holding on to objects Driving Climbing stairs

Keeping balance Financial Management Crouching/squatting

Lifting Getting places Doing things on time

Seeing Housework Eating

Making decisions Knitting Gardening

Personal hygiene Light/sound Hearing

Reaching out/up/down Moving joints Jogging

Shopping Pushing/pulling with feet Leaning

**What do you hope to gain from your visits?** 1.Be pain free 2. Explanation of my condition

3. Reduce symptoms 4. Resume normal activity 5. Learn how to care for my condition

**Lifetime Wellness-History-Page 4**

**Review of Systems**

**Constitutional** (Circle all that apply) Deny All \_\_\_\_\_\_

Chills Weight Loss Daytime Somnolence (Drowsiness)

Weight Gain Fever Fatigue Night Sweats

**Eyes/Vision** (Circle all that apply) Deny All \_\_\_\_\_\_

Blindness Blurred Vision Cataracts Itching (around eyes)

Eye Pain Field Cuts (Visual field defect) Glaucoma Double Vision

Tearing Wears glasses and/or contacts Change of vision Photophobia

**Ears, Nose and Throat** (Circle all that apply) Deny All \_\_\_\_\_

Bleeding Dental Implants Dentures Difficulty Swallowing

Dizziness Ear Drainage Ear Infections Ear Pain

Headaches Head Injury Hearing Loss Hoarseness

Nasal Congestion Nose Bleeds Post Nasal Drip Discharge

Snoring Tinnitus Rhinorrhea Fainting

Sore Throats TMJ Problems Sinus Infections Loss of Smell

**Cardiovascular** (Circle all that apply) Deny All \_\_\_\_\_

Angina Chest Pain Heart Murmur Shortness of breath with exertion

Heart Problems Ulcers Orthopnea (difficult breathing while lying down)

Swelling of Legs Varicose Veins Palpitations (irregular or forceful beating of heart)

**Respiration** (Circle all that apply) Deny All\_\_\_\_\_

Asthma Cough Coughing up blood Shortness of Breath Wheezing Sputum

**Gastrointestinal** (Circle all that apply) Deny All \_\_\_\_\_

Abdominal Pain Belching Constipation Abnormal Stool Consistency

Difficulty Swallowing Heartburn Indigestion Abnormal Stool Caliber (quality)

Nausea Rectal Bleeding Diarrhea

Vomiting Black, Tarry Stools Jaundice

Vomiting Blood Hemorrhoids Abnormal Stool Color

**Genitourinary** (Circle all that apply) Deny All \_\_\_\_\_

**Female:** Birth Control Irregular Menstruation Cramps Frequent Urination

Hormone Therapy Burning Urination Vaginal Bleeding

Breast Lumps/Pain Urine Retention Vaginal Discharge

**Male:** Burning Urination Erectile Dysfunction Frequent Urination Hesitancy/Dribbling

Prostate Problems

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**Skin** (Circle all that apply) Deny All \_\_\_\_\_

Change in Nail Texture Changes in skin color Hair Growth Hair Loss Hives Itching

Paresthesia (numbness, tingling, or prickling) Rash History of Skin Disorders

Skin Lesions/Ulcers

**Nervous System** (Circle all that apply) Deny All \_\_\_\_\_

Dizziness Facial Weakness Headaches Limb Weakness

Loss of Memory Numbness Seizures Sleep Disturbance

Stress Strokes Tremors Loss of Consciousness

Unsteadiness of Gait Slurred Speech

**Psychologic** (Circle all that apply) Deny All \_\_\_\_\_

Anxiety Confusion Appetite Changes Memory Loss

Bipolar Disorder Convulsions Insomnia

Mood Change(s) Depression Behavioral Changes

**Endocrine** (Circle all that apply) Deny All \_\_\_\_\_

Cold Intolerance Diabetes Hair Loss Excessive Thirst

Frequent Urination Goiter Excessive Hunger Unusual Hair Growth

Voice Changes Excessive Appetite Heat Intolerance

**Hematology** (Circle all that apply) Deny All \_\_\_\_\_

Anemia Blood Clotting Bruises Easily Lymph Node Swelling

Bleeding Blood Transfusion(s) Fatigue

**Allergy** (Circle all that apply) Deny All \_\_\_\_\_

Anaphylaxis (history of) Itching Nasal Congestion Sneezing

Food Intolerance