Chiropractic Center of Pelham Medical History Form

Patient Name:____ DOB:____________________

Primary Care Physician:____ Phone:___________________

When did you first notice symptoms?____

Is the condition getting better or worse? _____________________ If applicable, describe how it is changing?____

Where specifically is the problem(s) located? ___________________________

What activities are difficult to perform? (check) ___ Sitting___ Standing___ Bending___ Lying Down____

Other? __________________

Type of pain (check) ___Sharp ___Dull ___ Throbbing ___ Numbness ___ Tingling ___ Ache ___

Shooting ___ Cramping ___ Stiffness ___ Swelling ___Other? _________________

Rate the severity on 1-10 (1=mild 10=severe): At it's worst _____ At its best _____ Currently _____

Does the pain come and go or is it constant? ___________________

List and over the counter or prescription medication(s) you are currently taking. Name, quantity and the conditions taken for:____

Have you had surgery/treatment for this condition or ANY OTHER – Ever? Please specify in detail below.

____

Have you EVER had any of the following medical or rehabilitative services for this condition or any past conditions? Please check where appropriate.

___Chiropractic ___Physical Therapy ___MRI ___Massage Therapy ___Bone Scan
___Occupational Therapy ___Neurologist ___CT Scan ___EMG/NCV ___Podiatrist
___General Practitioner ___Emergency Room ___X-Rays ___Myelogram ___Orthopedist

Please check all that apply below past and/or current.

___Diabetes	___Excess Wt. loss/Gain	___Epilepsy/Seizures	___Osteoporosis/Osteopenia
___Anemia	___Thyroid Trouble/Goiter	___Chemical Dependency	___Fractures
___Heart Disease	___Cancer/Chemotherapy	___Emotional Problems	___Arm/Hand Surgery
___High Blood Pressure	___Organ Disease	___Infectious Disease	___Leg/Foot Surgery
___Heart Attack/Surgery	___Hepatitis	___Hernia	___Joint Replacement
___High Cholesterol	___Numbness/Tingling	___Headaches/Migraines	___Pins or metal Implants
___Stroke/TIA/CVA	___Dizziness/Fainting	___Visual/Hearing Problems	___Asthma
___Blood Clot	___Weakness	___Multiple Sclerosis	___Bronchitis
___Varicose Veins	___Urinary Problems	___Do you Drink? Qty?	___Emphysema
___Pacemaker	___Incontinence	___Are you pregnant	?___Allergies
___Pumps/Shunts etc.	___Sexual Difficulties	___Do you smoke? Qty?	___Gout

If yes from above, please explain in detail the dates and areas involved etc.:____

Authorization – I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any examination rendered to me or my child during this period of care to third party payers and or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group all insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services and I agree to be responsible for the payment of any and all services rendered on my behalf or my dependents.

X____ Date:_______________
Patient Signature (Guardian signature if minor)