# Nancy Hood Chiropractic Care

Thank you for selecting Nancy Hood Chiropractic Care! We will strive to provide you with the best possible healthcare. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us-we will be happy to help.

Patient Name_____ Birthdate_____ Patient #_____

Today's Date_____

Chief Complaint_____

History of present illness_____

Location_____
(Where is the pain/problem?)

Onset_____
(Initial cause of pain/problem?)

Severity_____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration_____
(How long have you had the pain/problem, or when did it start?)

Timing_____
(Does the pain/problem occur at a specific time?)

Quality_____
(Dull, ache, sharp, burning, etc.?)

Associated signs/symptoms_____
(What other associated problems have you been having?)

Modifying factors_____
(What makes the pain/problem worse or better? Have you had previous episodes

Past Medical History

Have you ever had the following: (Circle if yes, check if unsure)

| | | | |
|---|---|---|---|
| Measles | Venereal Disease | Blood or Plasma Transfusions | Stroke |
| Mumps | Anemia | Back Trouble | Hepatitis |
| Chickenpox | Bladder Infections | High Blood Pressure | Ulcer |
| Whooping Cough | Epilepsy | Low Blood Pressure | Kidney Disease |
| Scarlet Fever | Migraine Headaches | Hemorrhoids | Thyroid Disease |
| Diphtheria | Tuberculosis | Asthma | Bleeding Tendency |
| Smallpox | Diabetes | Hives or Eczema | Date of last chest X-ray _____ |
| Pneumonia | Cancer | AIDS or HIV + | Any Other Disease |
| Rheumatic Fever | Polio | Infectious Mono | Please List _____ |
| Heart Disease | Glaucoma | Bronchitis | _____ |
| Arthritis | Hernia | Mitral Valve Prolapse | _____ |

| Previous Hospitalizations/Surgeries/Serious Illnesses | When? | Hospital, City, State |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Medications(Include Nonprescription) _____

_____

Have you ever taken Phen-Fen/Redux? YES NO

## Patient Social History:

Marital status: _____Single _____Married _____Separated ____Divorced ____Widowed

Use of alcohol: _____Never _____Rarely _____Moderate _____Daily

Use of Tobacco: _____Never _____Previously, but quit _____Current, packs/day

Use of drugs: _____Never Type, Frequency:_____

Excessive Exposure

At home or work to: _____Fumes _____Dust _____Solvents _____Air-borne _____Particles _____Noise

Family Medical History:

| | Age | Disease | If Deceased, Cause of Death |
|---|---|---|---|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Spouse | _____ | _____ | _____ |
| Children | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

Review of systems- Please indicate any personal history below by circling the symptom:

### Constitution Symptoms
Good general health lately
Recent weight change
Fever
Fatigue
Headaches

### Eyes
Eye disease or injury
Wear glasses/contact lenses
Blurred or double vision

### Ears/Nose/Mouth/Throat
Hearing loss or ringing
Earaches or drainage
Chronic sinus problem or rhinitis
Nose bleeds
Mouth sores
Bleeding gums
Bad breath or bad taste
Sore throat or voice change
Swollen glands in neck

### Cardiovascular
Heart trouble
Chest pain or angina pectoris
Palpation
Shortness of breath w/ walking or lying flat
Swelling of feet, ankles or hands

### Respiratory
Persistent cough or throat clearing, not associated with known illness(lasting more than 3 weeks)
Spitting up blood
Shortness of breath
Wheezing

### Gastrointestinal
Loss of appetite
Change in bowel movements
Nausea or vomiting
Frequent diarrhea
Painful bowel movements or constipation
Rectal bleeding or blood in stool
Abdominal pain

### Genitourinary
Frequent urination
Burning or painful urination
Blood in urine
Change in force or strain when urinating
Incontinence or dribbling
Kidney stones
Sexual difficulty
Male- testicular pain
Female-pain with periods
Female-irregular periods
Female-vaginal discharge
Female-# of pregnancies
Female-# of miscarriages
Female- date of last pap smear

### Musculoskeletal
Joint pain
Joint stiffness or swelling
Weakness of muscles or joints
Muscle pain or cramps
Back pain
Cold extremities
Difficulty walking

### Integumentary (skin, breast)
Rash or itching
Change in skin color
Change in hair or nails
Varicose veins
Breast pain
Breast lump
Breast discharge

### Neurological
Frequent or reoccurring headaches
Light headed or dizzy
Convulsions or seizures
Numbness or tingling sensations
Tremors
Paralysis
Head injury

### Psychiatric
Memory loss or confusion
Nervousness
Depression
Insomnia
Suicidal thoughts
Violent or unusual thoughts

### Endocrine
Glandular or hormone problem
Excessive thirst or urination
Heat or cold intolerance
Skin becoming drier
Change in hat or glove size

### Hematologic/Lymphatic
Slow to heal after cuts
Bleeding or bruising tendency
Anemia
Phlebitis
Past transfusion
Enlarged glands

### Allergic/Immunologic
History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics
Morphine, Demerol, or other narcotics
Novocain or other anesthetics
Aspirin or other pain remedies
Tetanus antitoxin or other serums
Iodine, Merthiolate or other antiseptic
Other drugs/medications_____
_____
_____
_____
Known food allergies_____
_____
_____
_____
Environmental allergies_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Signature of Doctor Date