

Theriot Family Chiropractic Center

Personal and Family Health History

Name _____
Address _____
City _____ State _____ Zip _____
Phone (H) _____ (W) _____
E-mail _____
Social Security # _____
Date of Birth _____ Age _____

Date _____
Referred By _____
Occupation _____
Employer _____
Marital Status S M D W
Spouse's Name _____
Spouse's Occupation _____
Number of Children _____

Current Health Condition

Present complaint (reason for your visit today) _____

When did your symptoms/pain or problem start? _____

Was this a result of an accident or injury? Please describe _____

Is the pain: Sharp Dull Constant Intermittent (comes and goes)

How severe: no pain= 0 1 2 3 4 5 6 7 8 9 10= worst

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain time of the day? _____ when? _____

Is this condition: improving staying the same getting worse

Any home remedies? (i.e. ice/heat) _____

Your Activities of Daily Living and Work

Please circle any activities that are compromised by your current state of health.

Standing Walking Sitting Bending Climbing Stairs Cleaning Gardening

Chewing Sleeping Kneeling Lifting Exercising Other _____

Have you been to any other doctors for this condition? no yes What did they do? _____

Have you ever been to a doctor of chiropractic before? no yes How long ago? _____

Was it for the same condition? no yes Other: _____

Other Health Conditions:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Ears ring | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Fever | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Fainting | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Diarrhea |

Sickness, Injury and Accident History

Include Dates and Descriptions

Accidents (Include automobile, off-road, work-related, slips/falls)

Prior Illness (other than colds and flu)

Surgeries and Hospitalizations:

Please list any over-the-counter AND prescription medications that you are taking:

Drug:	For:	Drug:	For:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Which is your dominant hand: Left Right Ambidextrous

Which of the following best describes your stress level: None Minimal Moderate Extreme

Do you smoke? no yes How much _____ for how long _____

Do you exercise? no yes How often _____ what kind _____

How many caffeinated drinks do you consume per day? _____

How many alcoholic drinks do you consume per week? _____

Are you currently taking any vitamins or nutritional supplements? please list _____

WOMEN ONLY: To your knowledge are you pregnant? no yes Due date: _____

Is there a family history of: Heart Disease? Arthritis Cancer Diabetes Other _____

Father's side

Mother's side

As a result of my chiropractic care, I would like to:

(please check all that apply)

- feel better quickly.
- have a healthier spine.
- have a healthier body by keeping my nerve system healthy.
- live a healthier lifestyle.

signature

date