Paunicka Chiropractic Clinic

Confidential Health History

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State: _____ Date of birth: _____

Zip Code: _____ Sex: M or F

Soc Sec #: _____ Marital Status: M S W D

Employer: _____ Work Location: _____

Occupation: _____ Work Phone: _____

Please describe your health problem: _____

_____

_____

List any other doctors seen for this problem: _____

_____

List any diagnosis and/or treatments: _____

_____

List any health/medical diseases and year or occurrence/diagnosis: _____

_____

_____

Have you been treated for any health condition in the past year?: _____

_____

Have you received chiropractic treatment previously? If yes, explain: _____

_____

We greatly appreciate referrals to our office. So we may thank them, who referred you to our office or how did you hear of our office?: _____

Please check the condition(s) you are now having and those you frequently have.

MUSCULO-SKELETAL SYSTEM
___ Low back problems
___ Pain between shoulders
___ Neck problems
___ Arm problems
___ Leg problems
___ Swollen joints
___ Painful joints
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Ruptures
___ Broken Bones

GENITO-URINARY SYSTEM
___ Bladder trouble
___ Excessive urine
___ Scenty urination
___ Painful urination
___ Discolored urine

FEMALE
___ Vaginal discharge
___ Vaginal bleeding
___ Vaginal pain
___ Breast pain
___ Lumps on breast

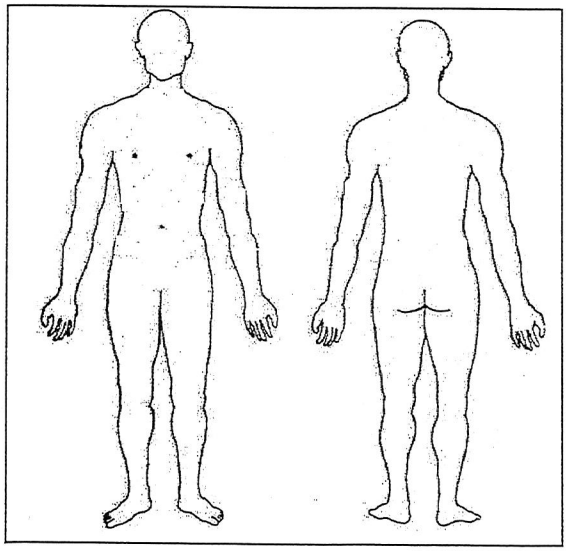
ARE YOU PREGNANT
___ Yes ___ No

GASTRO-INTESTINAL SYSTEM
___ Poor Appetite
___ Excessive hunger
___ Difficulty chewing
___ Difficulty swallowing
___ Excessive thirst
___ Nausea
___ Vomiting food
___ Vomiting blood
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Black stool
___ Bloody stool
___ Hemorrhoids
___ Liver trouble
___ Gall bladder problems
___ Weight trouble

NERVOUS SYSTEM
___ Numbness
___ Loss of feeling
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

CARDIOVASCULAR-RESPITORY
___ Chest pain
___ Pain over heart
___ Difficulty breathing
___ Persistent cough
___ Coughing phlegm
___ Coughing blood
___ Rapid heartbeat
___ Blood pressure problems
___ Heart problems
___ Lung problems
___ Varicose veins

EYE, EAR, NOSE AND THROAT
___ Eye strain
___ Eye inflammation
___ Vision problems
___ Ear pain
___ Ear noises
___ Hearing loss
___ Ear discharge
___ Nose pain
___ Nose bleeding
___ Nose discharge
___ Difficulty breathing through nose
___ Sore gums
___ Dental problems
___ Sore mouth
___ Sore throat
___ Hoarseness
___ Difficulty with speech



Please mark your areas of pain on the figures to left.

In case of emergency, please notify:
Name:

Address:

Phone:

Signature: _____

Paunicka Chiropractic Clinic

In accordance with the Patient Affordable Care Act of 2010, we are updating our records. Thank you for your cooperation.

Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip Code _____ Sex M or F

Occupation _____ Date of Birth _____

Employer _____ Right handed or Left handed (circle)

Family History	Diseases in the Family? (Arthritis, Heart Disease, Cancer, Diabetes, Multiple Sclerosis?)	Living or deceased?
Mother		
Father		
Brothers		
Sisters		
Grandmother(s)		
Grandfather(s)		

Please list ALL surgeries	Year of Surgery

Please any allergies to food, medication and other factors

Smoking Status:
Please check one:
____ Never a smoker

____ Current every day smoker _____ packs per day

____ Current periodic smoker. How often _____

____ Former Smoker. Quit in _____ year.

How many Children do you have? _____

Do you drink alcohol? _____ drinks per day/month (please circle)

Caffeine? How often? _____ How much? _____
What kind of caffeine (circle)? Coffee Soda Tea

Current Medications	**Dosage**

Signature _____

Date _____