

-----**PAST HISTORY**-----

Have you been to a Chiropractor before? YES or NO If yes, date of last adjustment _____

Reason for previous chiropractic care? _____

How often did you go? ___ Regular monthly check-ups ___ Bi-weekly ___ Weekly ___ Only when needed

Was there a reason you stopped going? _____

Medical Doctor _____ Other Physicians _____

Date of last medical examination _____ Any complications? _____

List any injuries or accidents & dates _____

List any surgeries & dates _____

List anything that you have been diagnosed with (either in the past or currently) _____

List prescription and non-prescription drugs or vitamins you take _____

Do you have a family history of any of the following? arthritis? _____ cancers? _____ diabetes? _____
heart disease? _____ scoliosis? _____

-----**PAST & PRESENT CONDITIONS**-----

(Please X all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Shoulder Pain (right/left) | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Colon Trouble |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Blurred or Doubled Vision | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Kidney Troubles |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Difficulty Urination |
| <input type="checkbox"/> Frequent Colds or Flus | <input type="checkbox"/> Stroke | <input type="checkbox"/> Prostrate Problems |
| <input type="checkbox"/> Trouble Concentrating | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Hernias | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Convulsion/Epilepsy | <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Low Back Pain/Stiffness |
| <input type="checkbox"/> Mental/Emotional Disorders | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Numbness in legs/feet/toe |
| <input type="checkbox"/> Neck Pain (right/left) | <input type="checkbox"/> Excessive Gas | <input type="checkbox"/> Hip Pain (right/left) |
| <input type="checkbox"/> Numbness in arms/hands/fingers | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> TMJ/Jaw Pain | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Swollen/Painful Joints |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Mid-back Pain/Stiffness | <input type="checkbox"/> Fractured Bones |
| <input type="checkbox"/> Knocked Unconscious | <input type="checkbox"/> Auto Accidents | where _____ |
| <input type="checkbox"/> Pass Out | <input type="checkbox"/> 0-1 yrs. Ago | _____ |
| <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> 1-5 yrs. Ago | _____ |
| | <input type="checkbox"/> +5 yrs. Ago | _____ |

Patient Signature _____ **Date** _____

FEMALE PATIENTS RECEIVING X-RAYS

Here at Clearfield Chiropractic, we want to ensure that each and every patient receives the safest care possible. If by chance you are pregnant, it is important that we protect you from any unnecessary radiation that could effect the development of an unborn child, in uterus.

Is there a chance that you may be pregnant at this time? YES / NO Date of last menses? _____

By signing your name below, you deny pregnancy at this time and give permission to proceed with your X-Ray as needed.

Signature _____ Date _____