Genesis Chiropractic And Rehabilitation Patient History Form

Is this visit due to an auto or workman's comp accident? □NO □YES

(If yes, please inform the front desk of this if you haven't already.)

Name:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email Address:_____Occupation:_____

Date of Birth:_____Gender: □ Male □ Female Social Security #: _____-_____-_____

Race: □ American Indian □ Asian □Black or African American □ Native Islander □White □ Decline

Ethnicity: □Hispanic/Latino □ Non-Hispanic/Latino□ Decline Preferred Language:_____

Are you Pregnant? □ Yes □ No Number of Children:_____Marital Status:_____

Primary Care Physician Name:_____Clinic Name/Location:_____

Who may we thank for referring you to our office?_____

Have you had x-rays, MRI, or CT scans completed? (if yes) When/Where/Area of body:_____

_____

Do you consume caffeine?	Never	< 3 Drinks/day	3-6 Drinks/day	>6 Drinks/day		
Do you consume alcohol?	Never	Casual Drinker	Moderate Drinker	Heavy Drinker		
Do you smoke?	Never	Current Smoke	Former Smoker			
Do you use drugs?	Never	Recreational	Addiction			
Do you exercise?	Never	Daily	Weekly	Walks	Runs	Swims

List ALL **Allergies (Medications/Food/Environmental)** :_____

_____

_____

List ALL **Surgeries (DATES INCLUDED):**_____

_____

_____

List ALL **Medical History** conditions:_____

_____

_____

List ALL **Medications/Vitamins** you are taking **(DATE STARTED)**_____

_____

_____

Genesis Chiropractic And Rehabilitation Patient History Form

Name:_____ Date:_____

Family Health History: Please write down any/all medical histories below that apply to the following family members.

Father:_____

Mother:_____

Brothers:_____

Sisters:_____

Son:_____

Daughter:_____

Paternal Grandmother:_____

Paternal Grandfather:_____

Maternal Grandmother:_____

Maternal Grandfather:_____

Please circle which daily living activities are bothered due to your current pain.
Please use the key below to help describe the symptoms that occur during these activities.
If the following is left blank it will be written in your notes that your pain is **not** affecting your Activities of Daily Living.

NT- NOT AFFECTED (Activity causes NO pain)	D- Difficult/Painful
AF- AFFECTED (Activity causes pain)	NA- Needs assistance
W- Pain is bothersome at work.	

Dressing_____ Grooming_____ Walking_____ Sitting_____

Sitting_____ Standing_____ Driving_____ Sleeping_____

Childcare_____ Lifting_____ In/out of bed_____ Sitting to standing_____

Climbing Stairs_____ Other(_____)_____ Other(_____)_____

Housework (list activities)_____ Exercise (list activities)_____

Genesis Chiropractic And Rehabilitation Patient History Form

For the following, please only fill out/circle what applies.

NECK PAIN **Date Started**:_____	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Side** Left/Center/Right	**How did pain start?** **Have you had similar pain before? (when)**
Is the pain… →	Constant 100-75% of time	Frequently 75-50% of time	Intermittent 50-25% of time	Occasional 25-0% of time
Is the pain… →	Sharp Shooting Stabbing Achy Dull Throbbing Tingling Numb Burning Tight	
What time of day does your pain feel BEST →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What time of day does your pain feel WORSE →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What makes the pain feel better? →	Resting	Stretching	Ice	Medication	Chiropractic Care	Other:
What makes the pain feel worse? →	Working	Standing	Twisting	Movement	Walking	Other:

UPPER/MID BACK PAIN **Date Started**:_____	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Side** Left/Center/Right	**How did pain start?** **Have you had similar pain before? (when)**
Is the pain… →	Constant 100-75% of time	Frequently 75-50% of time	Intermittent 50-25% of time	Occasional 25-0% of time
Is the pain… →	Sharp Shooting Stabbing Achy Dull Throbbing Tingling Numb Burning Tight	
What time of day does your pain feel BEST →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What time of day does your pain feel WORSE →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What makes the pain feel better? →	Resting	Stretching	Ice	Medication	Chiropractic Care	Other:
What makes the pain feel worse? →	Working	Standing	Twisting	Movement	Walking	Other:

Genesis Chiropractic And Rehabilitation Patient History Form

Name:_____ Date:_____

LOW BACK PAIN **Date Started**:_____	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Side** Left/Center/Right	**How did pain start?** **Have you had similar pain before? (when)**
Is the pain… →	Constant 100-75% of time Frequently 75-50% of time Intermittent 50-25% of time Occasional 25-0% of time	
Is the pain… →	Sharp Shooting Stabbing Achy Dull Throbbing Tingling Numb Burning Tight	
What time of day does your pain feel BEST →	Morning As the day progresses Afternoon Evening During the night Stays consistent	
What time of day does your pain feel WORSE →	Morning As the day progresses Afternoon Evening During the night Stays consistent	
What makes the pain feel better? →	Resting Stretching Ice Medication Chiropractic Care Other:	
What makes the pain feel worse? →	Working Standing Twisting Movement Walking Other:	

OTHER: _____ **Date Started**:_____	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Side** Left/Center/Right	**How did pain start?** **Have you had similar pain before? (when)**
Is the pain… →	Constant 100-75% of time Frequently 75-50% of time Intermittent 50-25% of time Occasional 25-0% of time	
Is the pain… →	Sharp Shooting Stabbing Achy Dull Throbbing Tingling Numb Burning Tight	
What time of day does your pain feel BEST →	Morning As the day progresses Afternoon Evening During the night Stays consistent	
What time of day does your pain feel WORSE →	Morning As the day progresses Afternoon Evening During the night Stays consistent	
What makes the pain feel better? →	Resting Stretching Ice Medication Chiropractic Care Other:	
What makes the pain feel worse? →	Working Standing Twisting Movement Walking Other:	