Evon Chiropractic

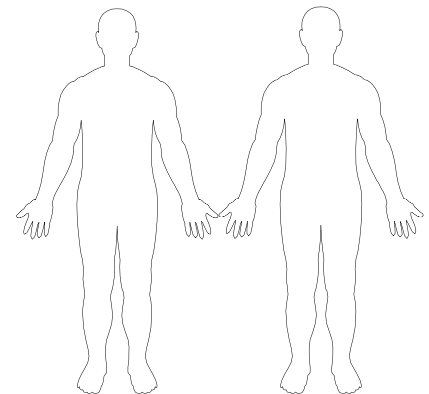
Patient
Inital Health History

Date: ____________________

☐ New Patient ☐ Update Patient
Patient's Name__________________________________ Date of Birth________________ ☐ Male ☐ Female
Address__________________________________ City ________________________ State__________ Zip___________
SS#______________________________ Home Phone ______________________ Work Phone ______________________
E-mail ___________________________________ Cell Phone ____________________________
Occupation ____ Marital Status ________________________
Employer's Name or School Name____
Insurance Company ____
Cash Patients: ☐ Cash Patient ☐ Staff cash ☐ PCD

CURRENT HEALTH CONDITION

Primary Complaint____
____
How did this condition develop (what caused it?)____
____
____
☐ Overexertion ☐ Strenuous Position ☐ Auto Accident ☐ Work Accident ☐ Fall ☐ Trip
When was the first time (date) you were aware of it?__________________
How would you describe the pain/symptoms?
☐ Dull Ache ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Other__________
How long do the pain/symptoms last?
☐ Intermittent ☐Occasional ☐ Frequent ☐ Constant
What aggravates the problem?
☐ Coughing ☐ Sneezing ☐ Lifting ☐ Bending ☐ Driving ☐ Riding
☐ Prolonged Sitting ☐ Walking ☐ Standing ☐ Sleeping ☐ Other____________
What relieves the problem?
☐ Rest ☐ Exercise ☐ Sitting ☐Standing ☐ Lying ☐ Other ________________
Have you ever had the same or similar problem before? ☐ Yes ☐ No
☐ Explain ____
Have you ever had medical treatment for this condition before? ☐ Yes ☐ No
By whom/when?____________________________________



X-dull ache **A**-stabbing pain ○-burning

Pain Scale (circle)

0	1 2 3	4 5 6	7 8 9	10
Normal	Low	Mod.	Increase	Emerg

PAST HEALTH HISTORY

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor (Explain)______________________________
Surgery____
Major accidents or falls______________________________________ Broken Bones____________________
Alcohol____________________ Tobacco__________________________ Allergies__________________________
Drugs/Medications (Current):____
Hospitalization Date(s)____
Reason____
Exercise: Amount__________________ Type_______________________ Difficulties________________________
Diet: ☐ Excellent ☐ Good ☐ Fair ☐ Poor (Explain)______________________________________
Family History: ____
____
Females: Pregnant? ☐ Yes ☐ No If yes, how long? ________________ Nursing child? ☐ Yes ☐ No
Additional history and Doctor notes____
____
____

Patient Signature: X___________________________________ **Date:** _______________
☐ Adult ☐ Parent/Guardian