CURRENT HEALTH HISTORY Date:_____

Name_____ DOB_____ Age:___ □ Male □ Female

Address_____City_____State_____Zip_____

Home Phone _____Work Phone_____Cell Phone _____

SS #_____-_____-_____ Email_____

SINCE YOUR LAST VISIT…

1) Have there been any changes to your health? YES NO Explain_____

2) Have there been any changes to your family history? YES NO Explain_____

3) Have there been any traumas, accidents or surgeries? YES NO Explain_____

_____

Please indicate in order of importance ALL complaints you are experiencing and briefly describe.

1st Complaint_____ It's getting: Better Worse No Change

a. Been a problem for: (please specify #) _____Day(s) _____Week(s) _____Month(s) _____Year(s)

b. Quality of symptom is: Sharp Dull Numb Tingling Burning Stiff Other_____ ***Mark areas below***

c. Condition came on: Sudden Gradual How:_____

d. It is: Constant / Frequent ***(daily)*** / Intermittent ***(several/wk)*** / Occasional ***(1/wk or less)***

e. Feels worse in: AM Noon PM In Bed Does it radiate? Yes No Where:_____

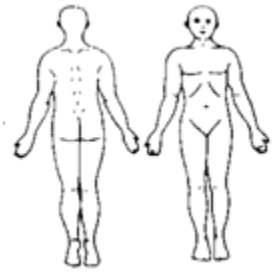
f. Rate on a scale of 1-10 *(10 = worst)* at its worst:_____

g. What makes it better?_____

h. What makes it worse?_____

i. Have you seen anyone for this? Yes No Who?_____

j. How does it interfere with your life (sleep, work, play, driving, lifting, etc.)_____



_____

2nd Complaint_____ It's getting: Better Worse No Change

a. Been a problem for: (please specify #) _____Day(s) _____Week(s) _____Month(s) _____Year(s)

b. Quality of symptom is: Sharp Dull Numb Tingling Burning Stiff Other_____ ***Mark areas below***

c. Condition came on: Sudden Gradual How:_____

d. It is: Constant / Frequent ***(daily)*** / Intermittent ***(several/wk)*** / Occasional ***(1/wk or less)***

e. Feels worse in: AM Noon PM In Bed Does it radiate? Yes No Where:_____

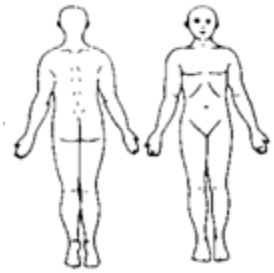
f. Rate on a scale of 1-10 *(10 = worst)* at its worst:_____

g. What makes it better?_____

h. What makes it worse?_____

i. Have you seen anyone for this? Yes No Who?_____

j. How does it interfere with your life (sleep, work, play, driving lifting, etc.)_____



_____

3rd Complaint_____

_____

Are ANY of the above complaints related to an auto or work injury? Yes No

Continued on back…

ACTIVITIES OF DAILY LIVING - In order to properly assess your condition, we must understand how much your health problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition currently.**

		0	1	2	3	4
1)	**Pain Intensity:**	None	Mild	Moderate	Severe	Unbearable
2)	**Frequency of Pain:**	None	25% of the day	50% of the day	75% of the day	Constant
3)	**Lifting:**	No Pain w/ Heavy Weight	Increased Pain w/ Heavy Wt.	Increased Pain w/ Moderate Wt.	Increased Pain w/ Light Wt.	Increased Pain w/ Any Wt.
4)	**Walking:**	No Pain w/ Any Distance	Increased Pain After 1 Mile	Increased Pain After ½ Mile	Increased Pain After ¼ Mile	Increased Pain w/ Any Distance
5)	**Standing:**	No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain After ½ Hour	Increased Pain w/ Any Standing
6)	**Travel:** (Driving)	No Pain on Long Trips	Mild Pain on Long Trips	Moderate Pain on Long Trips	Moderate Pain on Short Trips	Severe Pain on Short Trips
7)	**Work:**	Do Usual Work + Unlimited Extra	Do Usual Work But No Extra	Can do 50% of Usual Work	Can do 25% of Usual Work	Cannot Work
8)	**Sleeping:**	Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Severely Disturbed	Totally Disturbed
9)	**Personal Care:** (Washing, Dressing, etc.)	No Pain	Mild Pain	Moderate Pain	Severe Pain	Unbearable Pain
10)	**Recreation:**	Can do All Activities	Can do Most Activities	Can do Some Activities	Can do Few Activities	Cannot do Any Activities

Score:_____

Wellness Profile: Chiropractic care affects more than just muscles, joints and how we feel. Chiropractic helps our bodies function at a higher level which increases our overall health and wellness. Please share with us what health goals you hope to achieve. *(Circle as many goals as you wish)*

More Energy	Better Sleep	Freedom from Pain
Easier Breathing	Improved Posture	Improved Nutrition & Diet
Improved Coordination	Eliminate Medications	Improved Overall Health
Better Sports Performance	Stress Reduction	Better Concentration
Stronger Immune System	Other_____	

I understand that I am directly and fully responsible to BC Family Chiropractic for all fees associated with chiropractic care whether or not paid by insurance. If I have insurance, I authorize and assign all insurance benefits payable to me for services rendered if BC Family Chiropractic accepts assignment on my behalf. I authorize use of my signature below on all insurance submissions. Copies of any x-ray reports will be released upon written request, however the original films are the sole legal property of this practice and that by law the doctor must retain these films for a period of no less than 7 years. The above information is true and accurate to the best of my knowledge.

Patient Name	Patient Signature	Date	Dr. Initials
_____	_____	_____	_____

Informed Consent for Female Patients: By signing below I acknowledge that I understand the hazardous effects of x-rays to an unborn child and that I am not pregnant to the best of my knowledge. The first day of my last menstrual cycle was on _____. I hereby consent to have any diagnostic x-ray exam the doctor deems necessary.

Patient Signature	Date	Dr. Initials
_____	_____	_____