MEYER CHIROPRACTIC CENTER

Confidential Patient History

Major symptoms/complaints: _____

How did your symptoms start? _____ **Date condition began:** _____/_____/_____

Describe the nature of your symptoms: ☐Sharp ☐Burning ☐Radiating ☐Shooting ☐Stabbing
☐Throbbing ☐Tightness ☐Tingling ☐Dull ☐Numb ☐Other: _____

How often do you experience your symptoms? ☐Constantly (76-100% of the time) ☐Frequently (51-75% of the time)
☐Occasionally (26-50% of the time) ☐Intermittently (0-25% of the time)

Average pain intensity:
Last 24 Hours no pain 1 2 3 4 5 6 7 8 9 10 worst pain
Past Week no pain 1 2 3 4 5 6 7 8 9 10 worst pain

How much have your symptoms interfered with your usual daily activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

In general, how would you say your overall health is right now?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Other doctors or therapists who have treated THIS condition: _____

Major injuries or surgeries: _____

Medications & Usage: _____

Family doctor: _____ Are you pregnant? ☐Yes ☐No Date of last menstrual cycle: _____

Have you been in an auto accident or any other personal injury? When? Describe: _____

_____

Review of Systems

Please check conditions or symptoms you currently have or have had in the past:

☐AIDS/HIV	☐Epilepsy	☐High Blood Pressure	☐Multiple Sclerosis	☐Scarlet Fever
☐Arthritis	☐Eye Problems	☐High Cholesterol	☐Nausea	☐Spinal Conditions
☐Asthma	☐Goiter	☐Jaw Pain/TMJ	☐Neurological Problems	☐Stroke
☐Balance Impaired	☐Gout	☐Kidney Disease	☐Osteoporosis	☐Thyroid problems
☐Burning Eyes	☐Headaches	☐Knee Pain	☐Pacemaker	☐Tuberculosis
☐Cancer	☐Hearing Problems	☐Lightheadedness	☐Parkinson's	☐Tumors/growths
☐Depression	☐Heart Attack	☐Liver Disease	☐Pinched Nerve	☐Ulcers
☐Diabetes	☐Heart Disease	☐Loss of Grip	☐Pneumonia	☐Varicose Veins
☐Dizziness	☐Hepatitis	☐Loss of Concentration	☐Polio	☐Whiplash
☐Drug Use	☐Hernia	☐Loss of Memory	☐Prostate problems	☐Other _____
☐Eating Disorder	☐Herniated Disc	☐Menstrual Problems	☐Psychiatric	_____
☐Elbow Pain	☐Herpes	☐Mononucleosis	☐Rheumatoid Arthritis	_____

Exercise
☐None ☐Daily
☐Moderate ☐Heavy

Work Activity
☐Sitting ☐Light Labor
☐Standing ☐Heavy Labor

Lifestyle
☐Smoking Packs/Day ___ ☐Coffee/Caffeine Cups/Day_____
☐Alcohol Drinks/Day ____ ☐High Stress Level Reason: _____

_____ _____ _____

Printed Patient Name **Patient or Responsible Party's Signature** **Date**