

CHIEF COMPLAINT HISTORY

Please fill out all of the information found below to the best of your ability. Thank you.

Patient Name: _____ Date: _____ Age: _____ Height: _____ Weight: _____

COMPLAINT: _____

HISTORY OF PRESENT PROBLEM:

When did this problem begin? (Give date if possible): _____

What do you think caused it? _____

Is this a result of a work injury or auto accident? _____

Did it start suddenly or gradually? _____ Is it getting better, worse, or staying the same? _____

Describe the symptom? (Circle one or more): dull ache sharp stabbing numb throbbing burning tingling

How often does the symptom occur? (Circle one):
Constant (75-100% of the time) Frequent (50-74% of the time)
Occasional (25-49% of the time) Intermittent (1-24% of the time)

Circle the TWO numbers which best describe your symptom / pain intensity that you feel when it's the least painful and the most painful. (No Pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Does anything radiate into the arm / hands / legs / or feet? _____

What makes your problem worse? _____ What makes it better? _____

Any unusual weakness in arm / hands / legs / or feet? _____ Do you notice any lack of bowel / bladder control? _____

Have you been to any other healthcare provider for this problem? _____ If so, please give their name, tests / treatment administered and the results. _____

Who is your PCP (primary care physician)? _____ City _____

Do you give us permission to send your healthcare information (reports, office notes etc.) to your PCP? _____

Do you have a past history of this problem? _____ If so, when did you initially notice it and how many times in the past has it bothered you? _____

Have you been off work due to your complaint? _____ If so, during what dates? _____

How has this problem affected your normal activities of daily living and / or work activities? _____

What aspects of a healthy lifestyle do you feel you need some professional help with? (Circle one or more)

Pain Relief Exercise Strength Flexibility Nutrition Energy Other _____

DOCTOR'S NOTES: _____

Doctor's Initials: _____ **Date:** _____

PAST MEDICAL HISTORY:

Have you ever had any of the following? Circle all that apply and place a C (Current Problem) or a P (Past Problem) next to them.

- | | | | |
|------------------|-------------------|-----------------|---------------------|
| Measles | Epilepsy | Hiatal Hernia | Headache |
| Mumps | Tuberculosis | Thyroid Disease | Arthritis |
| Chickenpox | Polio | Kidney Disease | High Blood Pressure |
| Whooping Cough | Bladder Infection | Gall Stones | |
| Diphtheria | Glaucoma | Liver Disease | Any Other Disease? |
| Scarlet Fever | Blood Transfusion | Bronchitis | _____ |
| Pneumonia | Hernia | Stroke | _____ |
| Smallpox | Skin Condition | Heart Disease | _____ |
| Rheumatic Fever | Asthma | Blood Clots | _____ |
| Venereal Disease | Infectious Mono | Diabetes | _____ |
| AIDS or HIV+ | Ulcer | Hypoglycemia | |
| Anemia | Gastric Reflux | Cancer | |

PREVIOUS HOSPITALIZATIONS / SURGERIES / SERIOUS ILLNESS: _____ When _____ Hospital, City, State _____

ALLERGIC TO ANYTHING? _____

CURRENT MEDICATIONS: _____

PATIENT SOCIAL / OCCUPATIONAL HISTORY:

Place of work: _____ Position: _____ How Long? _____

Does your job require..... Prolonged sitting _____ Prolonged standing _____ Lifting _____ Bending _____

Marital status..... Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Exercise..... Never _____ Light _____ Moderate _____ Heavy _____

Use of alcohol..... Never _____ Rarely _____ Moderate _____ Daily _____ Quantity? _____

Use of tobacco..... Never _____ Previously, but quit _____ # of packs per day _____ How Long? _____

Caffeinated beverages..... Never _____ Cups / cans per day _____

Use of illicit drugs..... Never _____ Type / frequency _____

FAMILY MEDICAL HISTORY: (Please list below if any immediate relatives listed below have suffered from CANCER, DIABETES, HEART DISEASE, HIGH BLOOD PRESSURE, RESPIRATORY TROUBLE, KIDNEY DISEASE, MENTAL PROBLEMS, HEADACHES, BACK TROUBLE, or other health problems.)

	Age	If Living, Health Status	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

PERTINENT REVIEW OF SYSTEMS: Good general health lately? _____

Are you currently suffering from any of the following? Circle all that apply.

- | | | | |
|-----------------------------|-------------------------------|-------------------------|-----------------------|
| Recent weight change | Muscle pain or cramping | Convulsions or seizures | Difficulty speaking |
| Fever | Weakness in joints / muscles | Numbness or tingling | Nausea |
| Fatigue | Cold extremities | Double vision | Pain at night |
| Joint pain | Difficulty walking | Tremors | Difficulty swallowing |
| Back pain | Frequent headache | Paralysis | Other problems _____ |
| Joint stiffness or swelling | Light headedness or dizziness | Head injury | _____ |

To the best of my knowledge, I have answered all of the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to notify the doctor's office of any changes in my health status in the future. I authorize Dr. Engel to perform the necessary services I may need. I also authorize the release of my chiropractic records to any other health care provider involved in my care and to my insurance company when required.

Patient Signature: _____ Date: _____

Doctor's Notes: _____

Doctor's Initials: _____ **Date:** _____