



applied**CHIROPRACTIC**  
[of Troy]

50 Troy Town Dr Ste B, Troy OH 45373  
(937) 335-1551 • Fax (937) 335-1288  
www.appliedchiropracticof Troy.com

# WELCOME

## PATIENT INFORMATION

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name that I wish to be called

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Work Phone

Is it ok to call there?  YES  NO

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Occupation

Sex:  Male  Female

Marital Status:  Single  Married  Widowed  Separated  Divorced

\_\_\_\_\_  
Spouse's Name (if applicable)

**IN CASE OF EMERGENCY CONTACT:** (NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU)

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
How did you hear about us?



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# HEALTH HISTORY

## PRESENT CONDITION

What is the reason for your visit today? \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Are your symptoms getting progressively worse?     Yes     No     Not Sure

Please describe how it feels. (Check all that apply)

Sharp     Dull     Aching     Burning     Stabbing     Cramps

Tingling     Numb     Throbbing     Stiffness     Shooting     Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go?

Constant     On & Off – usually lasting: \_\_\_ Minutes    \_\_\_ Days    \_\_\_ Weeks

Does it interfere with your:     Work     Sleep     Recreation     Daily Routine

Activities that are painful to perform:     Sitting     Standing     Walking     Bending     Lying Down

Have you had anything like this before?     Yes     No

If Yes, when? \_\_\_\_\_

Is this condition due to an accident?     Yes     No

*If Yes, please answer the following:*

Date of accident: \_\_\_\_\_

Type of accident:     Auto     Work     Home     Other \_\_\_\_\_

To whom have you made a report of your accident?

Auto Insurance     Employer     Work Comp.     Other \_\_\_\_\_

What treatment have you already received for your condition?

Medications     Surgery     Physical Therapy     Chiropractic Services     None

Other \_\_\_\_\_

Please provide the name of any other health professional who has treated you for this condition:

\_\_\_\_\_

Is there any other information that you would like to the Doctor to know?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

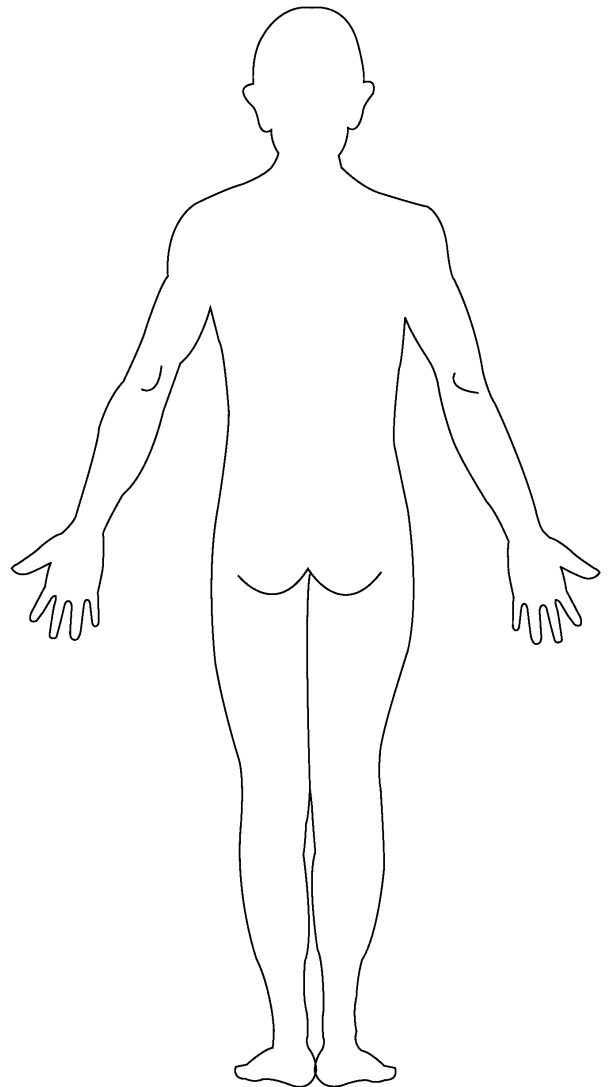
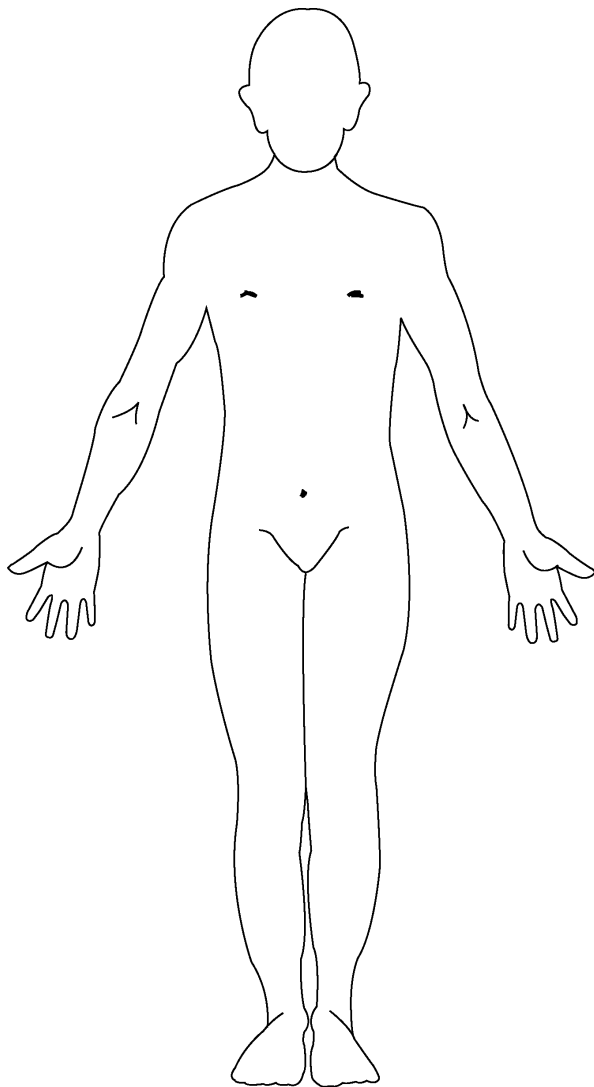
Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please rate your pain on the scales below, with 0="No Pain" and 10="Worst Pain Imaginable".

Today's Pain									
1	2	3	4	5	6	7	8	9	10
Typical Pain									
1	2	3	4	5	6	7	8	9	10
Pain when at its Worst									
1	2	3	4	5	6	7	8	9	10

Please mark area(s) of injury or discomfort on the diagram below with the following letters:

AAA=Aching    BBB=Burning    NNN=Numbness    PPP=Pins & Needles    SSS=Stabbing



Name: \_\_\_\_\_ Date: \_\_\_\_\_

# HEALTH HISTORY

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

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV         | <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Loss of Balance    | <input type="checkbox"/> Prosthesis           |
| <input type="checkbox"/> Acid Reflux      | <input type="checkbox"/> Concussion      | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Memory Loss        | <input type="checkbox"/> Pregnancy            |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Depression      | <input type="checkbox"/> Hernia           | <input type="checkbox"/> Mental Illness     | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Herniated Disc   | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Anorexia         | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Scarlet Fever        |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Drug Dependency | <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Ear Ringing     | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Nausea/Vomiting    | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Emphysema       | <input type="checkbox"/> Hoarseness       | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Hysterectomy     | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Tumors, Growths      |
| <input type="checkbox"/> Blood Clots      | <input type="checkbox"/> Fibromyalgia    | <input type="checkbox"/> Jaw Pain/TMJ     | <input type="checkbox"/> Parkinson's        | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Breast Lump      | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Joint Pain       | <input type="checkbox"/> Pinched Nerve      | <input type="checkbox"/> Varicose Veins       |
| <input type="checkbox"/> Bronchitis       | <input type="checkbox"/> Goiter          | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Vision Change        |
| <input type="checkbox"/> Bulimia          | <input type="checkbox"/> Gout            | <input type="checkbox"/> Lightheadedness  | <input type="checkbox"/> Polio              | <input type="checkbox"/> Whiplash             |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Liver Disease    | <input type="checkbox"/> Prostate Problems  | <input type="checkbox"/> Other                |

Please describe your past:

Date:

Car Accidents \_\_\_\_\_

\_\_\_\_\_

Head Injuries \_\_\_\_\_

\_\_\_\_\_

Falls \_\_\_\_\_

\_\_\_\_\_

Broken Bones \_\_\_\_\_

\_\_\_\_\_

Dislocations \_\_\_\_\_

\_\_\_\_\_

Hospitalizations \_\_\_\_\_

\_\_\_\_\_

Surgeries \_\_\_\_\_

\_\_\_\_\_

Please list:

Medications:

Taking it for:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Vitamins/Supplements:

Taking it for:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any Allergies? (Please list) \_\_\_\_\_

Have you received all scheduled Vaccinations?  Yes  No

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please check if any member of your family, living or deceased, has or had any of the following:

- |   |                                       |   |  |
|---|---------------------------------------|---|--|
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Mental Illness       | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Neurologic Disorders | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke               |  |

Please check your activity levels for the following:

- |                                   |  |                                   |                                      |
|-----------------------------------|--|-----------------------------------|--------------------------------------|
| EXERCISE                          |  | WORK                              |                                      |
| <input type="checkbox"/> None     | <input type="checkbox"/> ___ Days/Week | <input type="checkbox"/> Sitting  | <input type="checkbox"/> Light Labor |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> Heavy         | <input type="checkbox"/> Standing | <input type="checkbox"/> Heavy Labor |

Please check if any of the following apply:

- |   |   |
|---|---|
| <input type="checkbox"/> SMOKING<br>Packs / Day: _____<br>Date Began: _____ | <input type="checkbox"/> COFFEE / CAFFEINE<br>Cups / Day: _____ |
| <input type="checkbox"/> ALCOHOL<br>Drinks / Week: _____                    | <input type="checkbox"/> HIGH STRESS LEVEL<br>Reason: _____     |

Is there any other information that you would like to the Doctor to know?

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Name: _____	Date: _____
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