appliedCHIROPRACTIC
[of Troy]

WELCOME

223 East Main Street, Troy OH 45373
(937) 335-1551 ● Fax (937) 335-1288
www.appliedchiropracticoftroy.com

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?

____

____

____

____

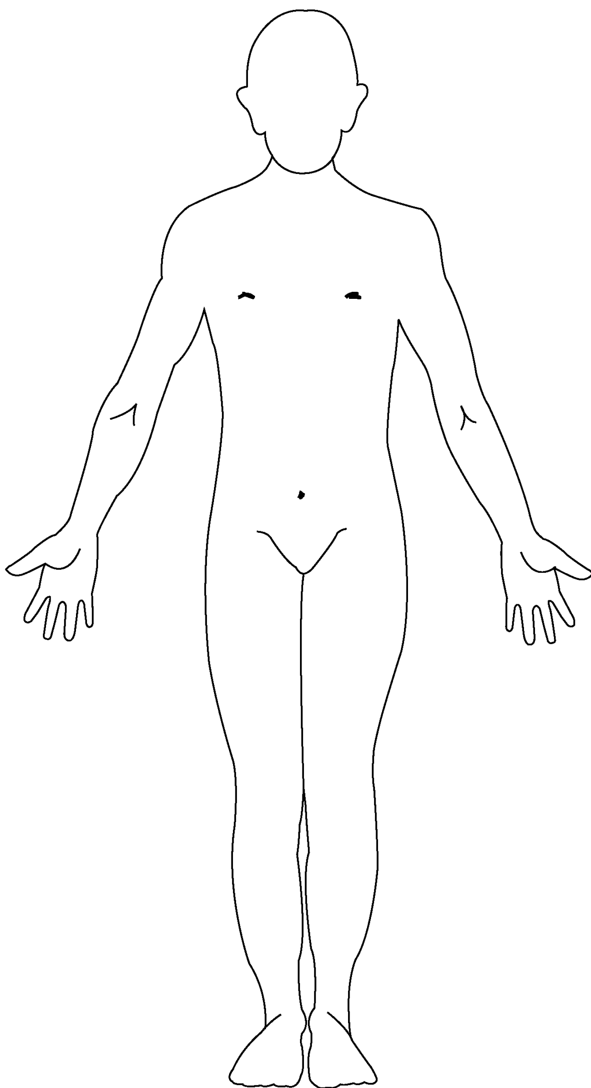
Name:____ Date:____________________

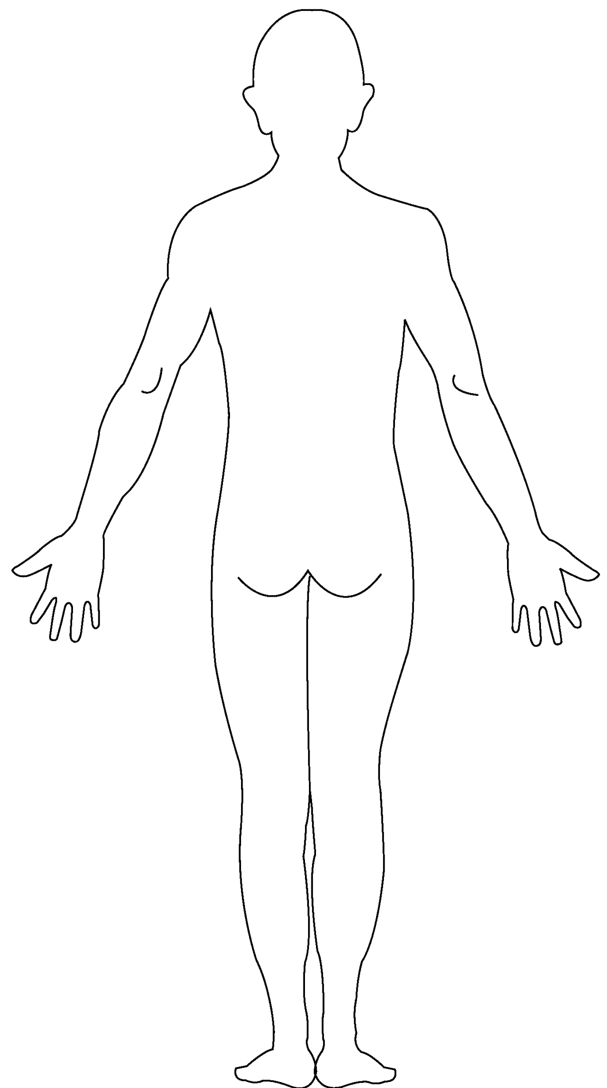
Please rate your pain on the scales below, with 0="No Pain" and 10="Worst Pain Imaginable".

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:

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

☐ Arthritis	☐ Diabetes	☐ Mental Illness	☐ Thyroid Disease
☐ Cancer	☐ Heart Attack	☐ Neurologic Disorders	☐ Ulcers
☐ Circulation Problems	☐ Hypertension	☐ Stroke	

Please check your activity levels for the following:

EXERCISE		WORK	
☐ None	☐ ____ Days/Week	☐ Sitting	☐ Light Labor
☐ Moderate	☐ Heavy	☐ Standing	☐ Heavy Labor

Please check if any of the following apply:

☐ SMOKING
Packs / Day:____________________
Date Began:____________________

☐ COFFEE / CAFFEINE
Cups / Day:________________________

☐ ALCOHOL
Drinks / Week:__________________

☐ HIGH STRESS LEVEL
Reason:___________________________

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

____

____

____

____

Name:____ Date:____________________