Plum Creek Chiropractic PA
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Name: ____ Date: ________________

Reason for visit: ____

When did your symptoms begin?____________________ Have you previously had similar symptoms? Y N

Have your symptoms changed in any way? Y N If so, how? ____

Does anything make your symptoms better? ____

Does anything make your symptoms worse? ____

Do they interfere with: work sleep daily routine recreation other: ____________________________

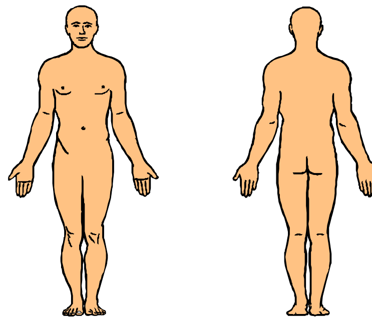
What is your opinion about the cause? ____

Have you seen any other providers for this condition?

Provider	Treatment Given	Helpful?	Treatment dates
____________________	____________________________________	Y N	___________________
____________________	____________________________________	Y N	___________________

Are you in pain? Y N Describe the location: ____

Mark an X on the picture to show where you feel pain.



What does the pain feel like? (circle all that apply)

sharp burning stabbing dull achy sore

weak throbbing tender numb tingling shooting tight cramping

pulling surface deep constant comes and goes

Rate your pain intensity (0=No pain, 10=Excruciating pain)

<0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10>

Activities that are painful to perform: sitting walking bending lying down other: _________

Past Health History

Have you had chiropractic care before? Y N Name of Doctor: _______________________________________

When was your last visit? _____________________

Date of last: Physical exam ____________ Spinal x-ray ____________ Blood test____________

Spinal exam ____________ Chest x-ray ____________ Urine test____________

Dental x-ray ____________ MRI, CT-scan, Bone scan____________

Discuss important results of these tests: ____

List any major surgeries or illnesses: ____

Have you ever been hospitalized? Y N If so, when ____

Do you have any allergies? Y N If so, list ____

CONDITIONS Check conditions you have or have had in the past:

? AIDS	? Chicken Pox	? Kidney Disease	? Rheumatoid Arthritis
? Alcoholism	? Diabetes	? Liver Disease	? Rheumatic Fever
? Anemia	? Emphysema	? Measles	? Scarlet Fever
? Anorexia	? Epilepsy	? Migraine Headaches	? Stroke
? Appendicitis	? Glaucoma	? Miscarriage	? Thyroid Problems
? Arthritis	? Goiter	? Mononucleosis	? Tonsillitis
? Asthma	? Gonorrhea	? Multiple Sclerosis	? Tuberculosis
? Bleeding Disorders	? Gout	? Mumps	? Tumors, Growths
? Breast Lump	? Heart Disease	? Osteoporosis	? Typhoid Fever
? Bronchitis	? Hepatitis	? Pacemaker	? Ulcers
? Bulimia	? Hernia	? Pneumonia	? Vaginal Infections
? Cancer	? Herpes	? Polio	? Venereal Disease
? Cataracts	? High Cholesterol	? Prostate Problem	? Whooping Cough
? Chemical Dependency	? HIV Positive	? Prosthesis	? Other ______________

Do you have a family history of: Heart Disease Lung Disease Diabetes Cancer Depression

Birth History (Please try to obtain this information, it can be important for your care.)

Did your mother have a difficult pregnancy with you? Y N

Describe: ____

Did your mother have any falls, accidents, or physical injuries during pregnancy? Y N

Describe: ____

Was your delivery difficult? Y N

Check all that apply: suction forceps "c" section cord around the neck breech drug induced pain medications prolonged labor

While pregnant with you, was your mother regularly taking any: medications alcohol or smoking?

During your delivery, was your mother: conscious semiconscious unconscious

Are there any chemicals your mother may have been exposed to during her pregnancy? Y N

Describe: ____

My birth was at: home birthing center hospital

Were you full term? Y N Were you incubated or isolated after birth? Y N

Vehicular accidents

Have you, even as a passenger or if you were fine, been involved in a moving vehicle collision or near collision?

Please list approximate dates and severity: mild, moderate or extreme.

Automobile: ____

Bus, Motorcycle: ____

Bicycle, Rollerblades, etc: ____

General Physical Trauma

Have you ever been knocked unconscious? Y N

Describe: ____

Have you ever broken any bones? Y N

Describe: ____

Have you ever had any impacts or falls that you felt specifically may have injured your head or spine or that required recovery time? Y N

Describe: ____

Have you had extensive dental or orthodontic work performed? Y N

Describe: ____

Sports and Leisure

Were you previously active in any particular sports or hobbies? Y N

Please list: ____

Are you currently active in any particular sports or hobbies? Y N

Please list: ____

Are there activities in which you spend any length of time in a particular position (TV, reading, musicians, etc.)?

Describe: ____

During the day I: (circle all that apply)

Sit Stand Walk Do phone work Drive Do mechanical work Do repetitive work Do heavy lifting

Do you exercise? Y N What do you do? ________________________________

How often? daily weekly monthly For how long? ______________minutes hours

Do you use safety equipment like bike helmets, wrist guards and seat belts? Y N

Have you been hurt in any of these activities? Y N

Describe: ____

Do you wear arch supports orthotics heel lifts?

How much sleep do you get? __________hours/night Do you sleep on your: side back stomach?

Chemical Exposure

Did you or do you work with any chemicals or in a place with fumes, dust or smoke for long periods? Y N

Describe: ____

Please indicate any **medications** you have taken in the past by circling P, or if you are currently taking it circle C.

Allergy/Cold/Flu	P	C	Aspirin/Tylenol/Ibuprofen	P	C	Laxatives	P	C
Antacids	P	C	Birth Control Pills	P	C	Lithium	P	C
Anti-anxiety	P	C	Blood pressure meds	P	C	Pain medications	P	C
Antibiotic	P	C	Cortisone	P	C	Pep pills/Stimulants	P	C
Antidepressant	P	C	Diabetic medications	P	C	Recreational	P	C
Antifungal	P	C	Heart medications	P	C	Relaxant/Sleeping pills	P	C
Anti-inflammatory	P	C	Hormones	P	C	Thyroid medications	P	C
Anti-parasitic(worms)	P	C	Insulin	P	C	Ulcer medications	P	C
Other	P	C	List:________________________					

What immunizations have you received? ________________________________

Are you now or have you ever used tobacco products? Y N What types do you use? ______________

Packs/tins per day _______for how many years __________

Dietary Choices

Approximately how much do you consume of each food item per **day**?

Fresh fruit	_______	Fresh vegetables	_______	Canned fruit	_______	Canned vegetables	_______
Fresh fish	_______	Canned fish	_______	Seafood	_______	Pork/Beef	_______
Chicken	_______	Eggs	_______	Whole grains	_______	Diet food	_______
Candy	_______	Junk food	_______	Fast food	_______	Fried food	_______

Do you take vitamins? Please list:____

____

____

Do you take herbs or homeopathy? Please list: ____

How many pats of butter _______ margarine _______ spread _______

How many glasses of water _______ beer _______ wine _______ alcohol _______

carbonated drinks _______ juice _______

How many cups of regular coffee _______ decaf coffee _______ black tea _______

green tea _______ herbal tea _______

How many slices of bread? __________ What kind of bread? __________________________________

Do you use salt sparingly moderately freely

What oils do you use in cooking? ____

What foods if any disagree with you? ____

What is your favorite food? ____

Do you have any food cravings?____

Do you feel your food habits are: excellent good fair poor They are: getting better getting worse

I usually have: ___________bowel movements per day Urination _________per day

Amount of Stress

Please indicate stress you have had in the past by circling P, or stress you are currently experiencing by circling C.

Indicate the intensity of the stress by choosing mild, moderate, or extreme.

	Mild	Moderate	Extreme		Mild	Moderate	Extreme
Childhood stress	P C	P C	P C	Work related stress	P C	P C	P C
School stress	P C	P C	P C	Stress of commuting	P C	P C	P C
Play or recreation	P C	P C	P C	Loss of loved one	P C	P C	P C
Family stress	P C	P C	P C	Major life change	P C	P C	P C
Stress of being sick	P C	P C	P C	Money stress	P C	P C	P C
Personal relationships	P C	P C	P C	Abuse	P C	P C	P C

Have you ever received professional help for any emotional or behavioral problems? Y N

Do you feel safe at home? Y N

Recent Health History

Have you had any recent weight change (loss or gain)? Y N Have you been trying to lose weight? Y N

Are you feeling unusually tired or fatigued? Y N

Have you had a recent abnormal temperature? Y N

GENERAL SYMPTOMS Check symptoms you currently have or have had in the past year

GENERAL
- ? Bruise Easily
- ? Chills
- ? Confusion
- ? Convulsions
- ? Dental Problems
- ? Depression
- ? Dizziness
- ? Fainting
- ? Fever
- ? Forgetfulness
- ? Headache
- ? Loss of Sleep
- ? Muscle Jerking
- ? Nervousness
- ? Numbness or Tingling
- ? Paralysis
- ? Sweats

GENITO-URINARY
- ? Blood in Urine
- ? Frequent Urination
- ? Lack of Bladder Control
- ? Painful Urination

GASTROINTESTINAL
- ? Appetite Poor
- ? Bloating
- ? Bowel Changes
- ? Constipation
- ? Diarrhea
- ? Excessive Hunger
- ? Excessive Thirst
- ? Gas
- ? Hemorrhoids
- ? Indigestion or Heart Burn
- ? Nausea
- ? Rectal Bleeding
- ? Stomach Pain
- ? Vomiting

CARDIOVASCULAR
- ? Chest Pain
- ? High Blood Pressure
- ? Irregular Heart Beat
- ? Low Blood Pressure
- ? Poor Circulation
- ? Rapid Heart Beat
- ? Swelling of Ankles
- ? Varicose Veins

E,E,N,T
- ? Bleeding Gums
- ? Blurred Vision
- ? Crossed Eyes
- ? Difficulty Swallowing
- ? Double Vision
- ? Earache or Discharge
- ? Hay Fever
- ? Hoarseness
- ? Loss of Hearing
- ? Nosebleeds
- ? Persistent Cough
- ? Ringing in Ears
- ? Sinus Problems
- ? Vision - Flashes
- ? Vision - Halos

SKIN
- ? Bruise Easily
- ? Hives
- ? Itching
- ? Change in Moles
- ? Rash
- ? Scars
- ? Sores That Won't Heal

MEN only
- ? Breast Lump
- ? Erection Difficulty
- ? Lump in Testicles
- ? Penis Discharge
- ? Sore on Penis
- ? Other ____________

WOMEN only
- ? Abnormal Pap Smear
- ? Breast Lump
- ? Hot Flashes
- ? Menstrual Pain
- ? Menstrual Spotting
- ? Nipple Discharge
- ? Painful Intercourse
- ? Vaginal Discharge
- ? Other ____________

For Women Only:

Are you still menstruating? Y N Date of most recent menstruation: ________________

Date of last pap smear: _____________ Have you had a mammogram? Y N Are you pregnant now? Y N

Age of first menses: ________ Number of pregnancies: ________ Number of children: ________

How were your pregnancies? ____

How were your deliveries? ____

Age of last menses: _________ Reason: ____________________________________

Rate your health:

(Low)0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10(High)

Family Health History (Parents and Siblings)

Arthritis	Drug Addiction	Mental Illness	Other
Asthma	Eating Disorder	Mental Handicap	
Alcoholism	Genetic Disorsder	Migraine Headaches	
Alzheimers	Glaucoma	Neuroligical Issues	
Cancer	Heart Disease	Obesity	
Depression	Infertility	Stroke	
Diabetes	Learning Disabilities	Suicide	

Is there anything else you feel I should know which has not been discussed?

Thank you for taking the time to help me understand your health.

Doctors notes:

BM:____

____

SLEEP:____

EXERCISE:____

____

BREAKFAST____

LUNCH____

DINNER____

SNACKS____

AVOIDED FOODS____

TOBACCO____

RECREATIONAL DRUGS____

____

____