Wise Chiropractic
and Rehabilitation Center
570.748.7462
5 West Main St., Lock Haven, PA 17745
www.wisechiropracticrehab.com

Date: ____________

Patient Health History

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

PATIENT INFORMATION

____
Name (First, Middle Initial, Last)

____
Name or Nickname I prefer to be called in this office

Male [ ] Female [ ]

______________ ________
Date of Birth Age

____
Street

____
Telephone (Home)

____
City State Zip

____
(Work) OK to call there? Yes [ ] No [ ]

____
Email

____
(Cell) OK to text you? Yes [ ] No [ ]

____
Cell Carrier (i.e Verizon, Sprint, ATT)

____
Social Security #

____
Occupation

____
Employer

Marital Status: Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Domestic Partner [ ]

Name of Spouse______________________________

Primary Care Physician ______________________________

Contact in Case of Emergency______________________________

Telephone # ______________________________

Name and Address of Parent of Minor Patient (If Applicable) ______________________________

____

Insurance BC/BS [ ] Medicare [ ] Cash [ ] WC [ ] PI [ ] Other______________

Current Complaints

Nature of injury: Auto [ ] Work [ ] Other [ ]

Please tell us why you are here: ______________________________

What do you think caused your condition? ______________________________

Date of injury: ____________ Date symptoms appeared: ____________

Have you ever had the same condition? Yes [ ] No [ ]
If yes, when? ______________________________

List other practitioners seen for this injury / condition ______________________________

Have you ever been under chiropractic care? Yes [ ] No [ ]
If yes, please describe:

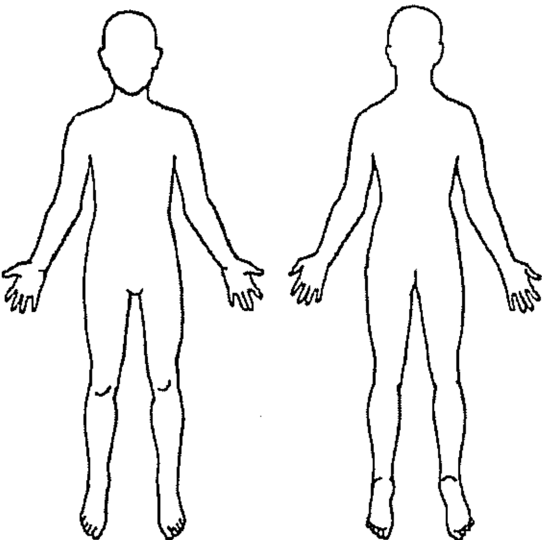
Do you experience pain every day?	Yes [ ]	No [ ]
Do your symptoms interfere with daily life?	Yes [ ]	No [ ]
Does pain wake you up at night?	Yes [ ]	No [ ]
Are your symptoms worse during certain times of the day?	Yes [ ]	No [ ]
Do changes in weather affect your symptoms?	Yes [ ]	No [ ]
Do you wear orthotics?	Yes [ ]	No [ ]

Have you had x-rays? Yes [ ] No [ ]
If yes, where? ______________________________ Date? ____________

Have you had an MRI? Yes [ ] No [ ]
If yes, where? ______________________________ Date? ____________

Please use the following letters to indicate **TYPE** and **LOCATION** of the symptoms you **CURRENTLY** are experiencing on the figures below.

A= Ache **B**= Burning **N**= Numbness **O**= Other
P= Pins & Needles **S**= Stabbing



Please rate your pain on the scale below:

(circle)

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

No Pain **Unbearable Pain**

Medical History

Have you been treated for any conditions in the last year? Yes [ ] No [ ]
If yes, please describe:

Are you taking any medications or over the counter drugs? Yes [ ] No [ ]
Type:

List allergies or adverse reactions to medications ______________________________

____

Have you ever:			**Explain:**
Broken bones?	Yes [ ]	No [ ]	______________
Been hospitalized?	Yes [ ]	No [ ]	______________
Been in an auto accident?	Yes [ ]	No [ ]	______________
Had sprains/strains?	Yes [ ]	No [ ]	______________
Been struck unconscious?	Yes [ ]	No [ ]	______________
Had surgery?	Yes [ ]	No [ ]	______________

Date of last physical exam ______________

Do you have:

Chest pain?	Yes [ ]	No [ ]
Any change in bowel or bladder habits?	Yes [ ]	No [ ]
A sore that does not heal?	Yes [ ]	No [ ]
Any unusual bleeding or discharge?	Yes [ ]	No [ ]
Thickening in your breasts or elsewhere?	Yes [ ]	No [ ]
Indigestion or difficulty in swallowing?	Yes [ ]	No [ ]
Any change in a wart or a mole?	Yes [ ]	No [ ]
A nagging cough or hoarseness?	Yes [ ]	No [ ]
Headaches for hours or days?	Yes [ ]	No [ ]
Blurred vision?	Yes [ ]	No [ ]
Night sweats?	Yes [ ]	No [ ]
Pain in your neck, jaw or face?	Yes [ ]	No [ ]
A drooping eyelid and/or change in pupils?	Yes [ ]	No [ ]
Vertigo (dizziness)?	Yes [ ]	No [ ]
Double vision?	Yes [ ]	No [ ]
Any visual disturbances?	Yes [ ]	No [ ]
Any nausea or vomiting?	Yes [ ]	No [ ]
Any slurred speech?	Yes [ ]	No [ ]
Any ringing in your ears?	Yes [ ]	No [ ]
A history of stroke in your family?	Yes [ ]	No [ ]
Do you pass out easily (faint)?	Yes [ ]	No [ ]
Do you take birth control pills?	Yes [ ]	No [ ]
Have you ever had cancer?	Yes [ ]	No [ ]
Are you losing weight without trying?	Yes [ ]	No [ ]
Are you coughing up blood?	Yes [ ]	No [ ]
Blood in your stools or urine?	Yes [ ]	No [ ]
Are you pregnant?	Yes [ ]	No [ ]
Have you had any loss of bladder or bowel control?	Yes [ ]	No [ ]
Are you a smoker?	Yes [ ]	No [ ]
If yes, how many a day? ______________		
Do you drink alcohol?	Yes [ ]	No [ ]
If yes, how much? ______________		

Family History

Did your mother or father have any of the following: Put an **M** for mother, **F** for father and **B** for both.

______ High Blood Pressure	______ Asthma	______ Ulcer or Stomach Problems	______ Thyroid Disease
______ Heart Attack	______ Diabetes	______ Circulation Problems	______ Stroke
______ Emphysema	______ Cancer	______ Arthritis-Rheumatism	______ Kidney Disease
______ Seizures/Convulsions	______ Pacemaker	______ Mental Illness	______ Osteoporosis

Comments ______________________________

____

____