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This information is strictly confidential. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Please be as accurate as possible.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that all examinations and treatments are to be paid for as they are received unless definite financial arrangements are made in advance.

I hereby authorize Dr. Lydia Knutson or Dr. Theresa Hopkins to examine and treat my condition as she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

Signature of Patient, Spouse or Guardian ______________________ Date ______________

PLEASE DO NOT WEAR PERFUMES, AFTERSHAVES OR OTHER SCENTS TO THIS OFFICE.
SOME PATIENTS ARE ALLERGIC.

PATIENT INFORMATION

Name ______________________ Today's Date ______________________

Address ______________________ Employer ______________________

City, State, Zip: ______________________ Type of work ______________________

______________________ If retired, what was your occupation? ______________________

Phone (home) ______________ (cell) ______________ (work) ______________

Email ______________________ Gender: F M Other

Social Security Number ______________________ Date of Birth ______________ Age __________

Marital Status: S M W D Partnered Height: _____ ft _____ in Current weight: __________

Name of Spouse/Partner ______________________ Lowest adult weight _____ Highest _____ Desired _____

Spouse's Occupation ______________________ Medical Doctor ______________________

Travel time to this office ______________________ Referred to our office by ______________________

Name(s) and Age(s) of Children ____

Other Household Members (include extended family, non-family and pets) ______________________

____

Name of person responsible for payment of professional services ______________________

CURRENT HEALTH REPORT

Please describe the principal health problems for which you came to this office. Include approximate date of onset.

1. ____
   ____
2. ____
   ____
3. ____
   ____

What are your long-term goals in coming to this office? ______________________________

How long has it been since you really felt good? ______________________________

Are your present complaints due to an injury? no yes auto accident other______________________________

____

Is your condition getting progressively worse? no yes • Pain is: constant comes and goes

Is your condition interfering with your: work sleep daily routine other ______________________________

Have you lost any days of work? no yes Dates ______________________________

What activities aggravate your condition? ______________________________

____

____

What makes it feel better? ______________________________

____

Have you had this or a similar condition before? no yes If yes, explain ______________________________

____

Has anyone in your family had a similar condition before? no yes If yes, who? ______________________________

Past chiropractic treatment no yes When? ____________ Explain ______________________________

____

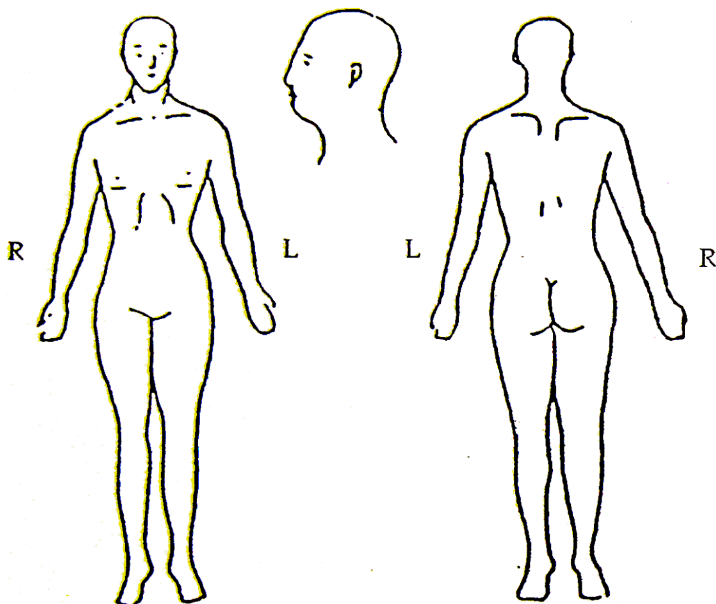
Have you seen any other physicians for this condition? ______________________________

List diagnoses and describe treatment ______________________________

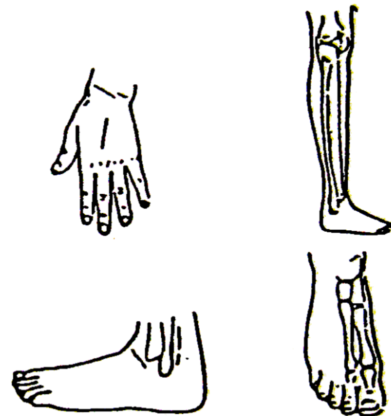
____

____

Please mark area and type of pain on the drawings using the codes listed below.



N = Numbness P = Pain
T = Tingling A = Ache
S = Soreness ST = Stiffness



Do you wear: Glasses/contacts Heel lifts Orthotics Dental night guard

Did/do you wear dental braces? no yes When? ______________________________

Have you been treated for any other health condition by a physician in the last year? no yes If yes, explain ______

____

Are you currently taking prescription medication? no yes If yes, what? ______________________________

____

Have you ever been on frequent or prolonged antibiotic therapy (such as erythromycin, penicillin, tetracycline, etc.)?
Please describe: ____________________

Current non-prescription medications (laxatives, aspirin, antihistamines, decongestants, stimulants, etc.) ____________________

Are you currently taking any vitamins or supplements? no yes If yes, what? ____________________

Allergies or sensitivities to drugs, foods, pollens, chemicals, animals, etc. ____________________

HABITS OF DAILY LIVING

Exercise: None Moderate Heavy • <1 per week 1-3 times per week Daily • Hours/ week _____

Work Activity (check all that apply): Sitting Standing Walking Light Labor Heavy Labor

Stress level: High Moderate Low • Do you do any stress reduction or relaxation activities such as meditation, yoga, prayer, etc.? ____________________

Are you currently on psychotropic medication or receiving psychological counseling? Please describe: ____________________

What are your favorite hobbies or other life interests? ____________________

Sleep habits: Hours per night ________ Restless or restful? ________ Do you dream? ________

What time do you go to bed? ________ Do you sleep through the night? ________

Alcohol consumption: Drinks per week ________ Have you ever felt the need to cut down? ________

Tobacco consumption: Do you smoke? ________ How much per day? ________ How long? ________

Did you ever smoke? ________ How much for how long? ________ When did you stop? ________

Non-medical drug use: Type and frequency ____________________

Chemical exposure: Do you regularly use: Cosmetics Perfumes Aftershaves Scented soaps/products

Do you have amalgam dental fillings? yes no • Any prolonged exposure to paints or solvents? yes no

Other known notable chemical exposures: ____________________

Diet: Do you eat regular meals? yes no • Do you sit down for meals? yes no • Do you normally eat or drink between meals? yes no What? ____________________

How often does your diet consist mainly of some or all of the following: salads, whole grains, eggs, fresh fruits and vegetables, lean meats, beans or legumes? rarely sometimes often almost always

Are you a vegetarian? yes no • Do you eat processed foods with artificial colorings, flavorings or preservatives (e.g. bologna, sausage, cheese spreads, baked goods)? rarely sometimes often

Do you eat "fast food"? rarely sometimes often What and how often? ____________________

Do you add sugar to coffee, tea, cereals, other foods? yes no • Do you use artificial sweeteners? yes no

How many servings of:

____ Fruit/day	____ Fish/week	____ Water/day	____ Tea/day
____ Vegetables/day	____ Fowl/week	____ Soft Drinks/day	____ Chocolate/Cocoa/day
____ Sweets/day	____ Red meat/week	____ Coffee/day	____ Cow dairy/day (cheese, milk, yogurt)

GENERAL HEALTH HISTORY

List any major accidents, serious falls or injuries (with dates) ____________________

____

Broken bones, cranial injuries ____________________

____

List surgeries/hospitalizations (with dates) ____________________

____

List X-rays or special imaging taken in the last 10 years and their dates____________________

____

Please check all that you have or have had:

Alcoholism	Diabetes	Lupus	Polio
Anemia	Dyslexia	Migraine Headaches	Rheumatism
Appendicitis	Diverticulitis	Malaria	Rheumatoid Arthritis
ADD/ADHD	Epilepsy	Measles	Scoliosis
Osteoarthritis	Goiter	Mental Illness	Stroke
Cancer	Grave's Disease	Multiple Sclerosis	Tuberculosis
Cerebral Palsy	Hashimoto's Disease	Muscular Dystrophy	Typhoid Fever
Chronic Fatigue	Heart Disease	Osteopenia	Ulcers
Cold Sores/Fever Blisters	Hepatitis	Osteoporosis	Venereal Disease
Colitis/Bowel Disease	HIV Positive	Pleurisy	Whooping Cough
Crohn's Disease	Influenza	Pneumonia	Other____________
Depression	Learning Disability		

Have you ever lived or traveled outside of the United States? yes no • Had travelers diarrhea? yes no

Have you ever been tested for intestinal parasites? yes no • Been treated for intestinal parasites? yes no

If yes, please describe when, and what parasite(s) ____________________

CHILDHOOD HISTORY

Were you breast or bottle fed? __________ Vaginal birth or C-section? __________ Complications? ____________________

____

Childhood illnesses:

Allergies	Chicken Pox	Mumps	Rheumatic Fever
Bedwetting	Colic	Persistent Diaper Rashes	Other ______________
Bronchitis	Ear Infections	Recurrent Colds	Frequent Antibiotics

Was your home life (check all that apply):

Loving	Fun	Loud	Alcoholic
Supportive	Educational	Argumentative	Single Parent
Peaceful	Stressful	Verbally Abusive	Lonely or Neglectful
Filled with positive extended family	Financially Stressed	Physically or Sexually Abusive	

Comments: ____________________

FAMILY HISTORY

	Diabetes	Heart Disease/High Blood Pressure	Cancer	Musculoskeletal Problems	Other ____________
Grandparent(s)					
Mother					
Father					
Sibling(s)					

Number of siblings _______ Sibling age(s) and health status ____

Age of biological parents __________ If deceased, age and cause: ______________________________________

SYSTEMS REVIEW

Please check appropriate box for any of the following symptoms that you have now or had previously.

P = In the past O = Occasionally in the present C = Constantly in the present

P O C **GENERAL**
- Allergies
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of Sleep
- Nervousness
- Night Sweats
- Thirst Abnormal
- Weight Loss
- Weight Gain

GASTRO-INTESTINAL
- Belching or gas
- Colon trouble
- Constipation
- Diarrhea
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (piles)
- Intestinal parasites
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Poor digestion
- Vomiting

THYROID
- Overactive
- Underactive
- Enlarged

P O C **MUSCLES & JOINTS**
- Arthritis
- Bursitis
- Hernia
- Leg cramps when walking
- Low back pain
- Musculoskeletal birth defects
- Neck pain or stiffness

Pain, numbness or tingling in:
- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Painful tailbone
- Paralysis
- Poor posture
- Sciatica
- Stiff neck
- Spinal curvature
- Swollen joints

SKIN
- Boils
- Bruising easily
- Dryness
- Eczema
- Psoriasis
- Hives or allergies
- Itching
- Sensitive skin
- Skin eruptions

P O C **CARDIOVASCULAR**
- Easy Bruising
- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart
- Slow heart
- Swelling ankles
- Varicose veins

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EYE/EAR/NOSE/THROAT
- Crossed eyes
- Dry eyes
- Eye pain
- Farsightedness
- Nearsightedness
- Light sensitivity
- Earache
- Ear discharge
- Ear noises
- Hearing difficulty
- Hearing sensitivity
- Nasal obstruction
- Nose bleeds
- Sinusitis
- Stuffy nose
- Hay fever
- Frequent colds
- Hoarseness
- Sore throats
- Enlarged glands
- Enlarged thyroid
- Dental decay
- Grinding teeth

P O C **RESPIRATORY**
- Asthma
- Chest pain
- Chronic cough
- Difficulty breathing
- Spitting blood
- Spitting phlegm
- Wheezing

GENITO-URINARY
- Bed wetting
- Blood in urine
- Frequent urination
- Incontinence
- Kidney infection
- Kidney stones
- Night urination
- Painful urination
- Prostate trouble

FOR WOMEN ONLY
- Cramps or backache
- Excessive flow
- Hot flashes
- Irregular cycle
- Lumps in breast
- Miscarriage
- Painful periods
- PMS
- Vaginal discharge

Y N Pregnant at this time?

Last Pap ______________

Menstrual cycle: ______ days

Date of last period: _________