ADVANCED CHIROPRACTIC

7349 Chapman Highway, Knoxville, Tennessee 37920

Health History

Name: **Chart #:** **Today's Date:** **Date of Onset:**

Please select all choices that apply to the patient.

☐ Abdominal Pain	☐ Colitis	☐ Headaches	☐ Irritable Colon	☐ Osteoporosis	☐ Sinus Trouble
☐ Allergies	☐ Colon Cancer	☐ Heart Attacks	☐ Kidney Disease	☐ Painful Urination	☐ Spinal Disc Disorder
☐ Angina	☐ Convulsions	☐ Heart Disease	☐ Kidney Stones	☐ Peptic Ulcer	☐ STDs
☐ Anorexia	☐ Diabetes	☐ Hepatitis A	☐ Kyphosis	☐ PMS	☐ Stomach Cancer
☐ Aortic Aneurysm	☐ Juvenile Diabetes	☐ Hepatitis B	☐ Leg Pain	☐ Polio	☐ Stomach Ulcer
☐ Arthritis	☐ Adult Diabetes	☐ Hepatitis C	☐ Liver Disease	☐ Profuse Menstrual	☐ Stroke
☐ Asthma	☐ Dislocated Joints	☐ High Blood Pressure	☐ Lordosis	☐ Prostate Cancer	☐ Thyroid Disorder
☐ Blood Disorder	☐ Dizziness	☐ Hip Pain	☐ Low Blood Pressure	☐ Prostate Problems	☐ Traumatic Arthritis
☐ Bone Cancer	☐ Duodenum Ulcer	☐ HIV/AIDS	☐ Lower Back Pain	☐ Rapid Heart Rate	☐ Tuberculosis
☐ Brain Cancer	☐ Emphysema	☐ Hypertension	☐ Lung Cancer	☐ Rectum Cancer	☐ Ulcer
☐ Breast Soreness	☐ Epilepsy	☐ Hyperthyroidism	☐ Lung Disease	☐ Rheumatoid Arthritis	☐ Upper Back pain
☐ Breast Cancer	☐ Esophageal Cancer	☐ Hypotension	☐ Migraine	☐ Rheumatic Fever	☐ Vaginal Discharge
☐ Bulemia	☐ Fainting	☐ Hypothyroidism	☐ Multiple Sclerosis	☐ Scoliosis	☐ _____
☐ Cancer	☐ Gouty Arthritis	☐ Irregular Bowel Habits	☐ Neck Pain	☐ Shoulder Pain	☐ _____
☐ Chest Pain	☐ Hay Fever	☐ Irregular Menstrual	☐ Osteoarthritis	☐ Sickle Cell Anemia	☐ _____

Select all choices that apply to the patient's family (please do not include relations by marriage).

☐ Abdominal Pain	☐ Colitis	☐ Headaches	☐ Irritable Colon	☐ Osteoporosis	☐ Sinus Trouble
☐ Allergies	☐ Colon Cancer	☐ Heart Attacks	☐ Kidney Disease	☐ Painful Urination	☐ Spinal Disc Disorder
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☐ Cancer	☐ Gouty Arthritis	☐ Irregular Bowel Habits	☐ Neck Pain	☐ Shoulder Pain	☐ _____
☐ Chest Pain	☐ Hay Fever	☐ Irregular Menstrual	☐ Osteoarthritis	☐ Sickle Cell Anemia	☐ _____

Smoking: ☐ Current Every Day ☐ Current Some Day ☐ Former ☐ Never

Tobacco: ☐ Current Every Day ☐ Current Some Day ☐ Former ☐ Never

Medications (Please list the medication and the dosage, include vitamins and supplements):

Medication	Dosage	Medication	Dosage

Please List Allergies and Your Reaction to the Allergy:

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Who is/was your most recent general physician? _____ What was his/her diagnosis? _____

Who was your last Doctor? _____ What were his/her findings? _____

Please list any previous injuries and/or accidents with approximate dates: _____

Past Surgical History (include date, location, surgeon's name, the type of surgery, and list complications):

_____ _____

_____ _____

Past Hospitalizations (date, complications, and cause of hospitalization):

_____ _____

_____ _____

History of Pregnancy: _____

Treatment and Diagnosis:

☐ Plain X-Rays	Date _____	Location _____	Results _____
☐ CT Scan	Date _____	Location _____	Results _____
☐ MRI	Date _____	Location _____	Results _____
☐ EMG	Date _____	Location _____	Results _____
☐ Thermogram	Date _____	Location _____	Results _____
☐ Bone Scan	Date _____	Location _____	Results _____
☐ Discogram	Date _____	Location _____	Results _____
☐ Myelogram	Date _____	Location _____	Results _____

☐ Nerve Block Injection	☐ Facett Injection	☐ Bioelectric Treatment	☐ Other _____
☐ Trigger Point Injection	☐ Tendon Sheath Injection	☐ EMG Needle Exam	☐ Other _____
☐ Joint Injection	☐ Botox Injection	☐ Spinal Infusion Pump	☐ Other _____
☐ Epidural Injection	☐ IV	☐ Spinal Cord Stimulator	☐ Other _____

_____ _____

I understand that the information I have provided above is current and complete to the best of my knowledge. Initial

Current Complaint

Name: _____ **Chart #:** _____ **Today's Date:** _____ **Doctor:** _____

What is your current complaint? (why are you seeking treatment?) _____

How severe is this problem?
- ☐ Mild
- ☐ Mild to Moderate
- ☐ Moderate
- ☐ Moderately Severe
- ☐ Severe

How Frequently?
- ☐ Constant
- ☐ Occasional
- ☐ Intermittent
- ☐ Frequent

On a 1-10 scale, how would you rate your pain?
(10 - most painful, 1 = least painful)

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

Improvement (%)

☐ 10%	☐ 60%
☐ 20%	☐ 70%
☐ 30%	☐ 80%
☐ 40%	☐ 90%
☐ 50%	☐ 100%

When was the onset of this problem?

☐ Gradual	☐ About a day ago	☐ About a month ago
☐ Sudden	☐ Several days ago	☐ Several months ago
☐ Insidious	☐ About a week ago	☐ About a year ago
	☐ Several weeks ago	☐ Several years ago

Select each choice that applies to you.

Movement
- ☐ Cramps
- ☐ Inflexibility
- ☐ Restricted Movement
- ☐ Spasm
- ☐ Stiffness

Sensation
- ☐ Crawling
- ☐ Dead
- ☐ Numb
- ☐ Pins and Needles
- ☐ Prickly
- ☐ Tingling

Select the type of pain that best describes your complaint.

☐ Achy	☐ Numb ache	☐ Shooting
☐ Burning	☐ Pounding	☐ Stabbing
☐ Dull	☐ Pulsating	☐ Stinging
☐ Excruciating	☐ Sharp	☐ Throbbing

How severe is this problem?
- ☐ Usually better in the morning
- ☐ Usually better during the day
- ☐ Usually better at night

_____
_____
_____
_____

Please indicate everything that makes you feel worse or aggravates your condition.
- ☐ Usually better in the morning
- ☐ Usually better during the day
- ☐ Usually better at night

_____
_____
_____
_____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____