CITY CHIROPRACTIC • Jackson Tower • 806 SW Broadway • Suite 350 • Portland, OR 97205 • 503/224-9513

New Patient History

Date _____ Patient s full name _____ Age _____ Sex M F

Right / Left Handed Height _____ Weight _____ Occupation _____

Date of injury or onset of symptoms _____ Have you missed work? Yes No If yes, # days lost_____

List complaints/symptoms _____

Describe accident, injury, or illness (if applicable) _____

Have you had a same or similar condition before? Yes No Number of times _____

What makes symptoms worse?_____

What makes symptoms better? _____

Are you getting: ❒ Better ❒ Worse ❒ Same Are your symptoms better in ❒ A.M. ❒ Midday ❒ P.M. ❒ In bed

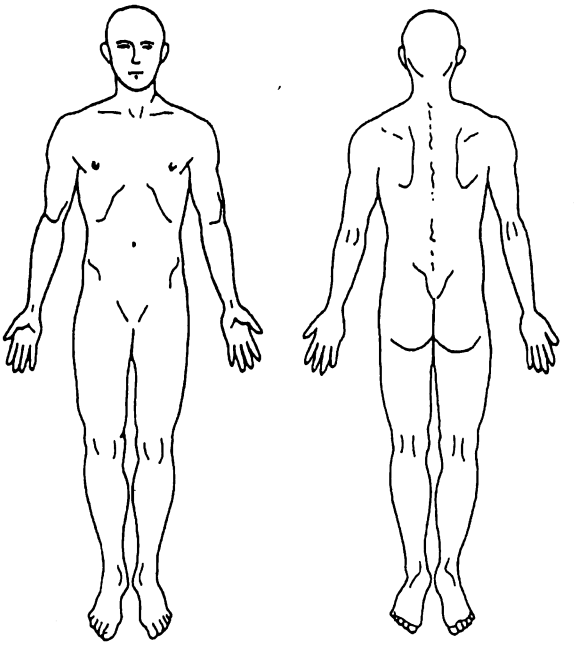
What other Doctors / Treatments have you tried for this condition? _____

PAIN DRAWING/QUALITY RADIATION

TELL/SHOW US WHERE YOU HURT

Please read carefully: *Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below:*

Ache	>>>> >>>>
Burning	xxxx xxxx
Numbness	==== ====
Stabbing	//// ////
Pins and Needles	oooo oooo
Throbbing	~~~~ ~~~~



For Office Use Only
❒ 1
❒ 4-5
❒ >5

Severity of Symptoms:

❒ Tolerated Annoyance ❒ ❒ Interferes with activities Do them anyway ❒ ❒ Can't do some activities Tolerate some activities ❒ ❒ Can't do anything

Visual Analogue Pain Scale *Circle the number which best describes your pain.*

How much pain have you had because of your condition in the past week?

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 PAIN AS BAD AS IT COULD BE

Slight Severe

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Duration / Frequency of Pain *How much of the day are you in pain?*

❒ <25% of Day Intermittent ❒ 25-50% of Day Occasional ❒ 50-75% of Day Frequent ❒ >75% of Day Constant

Average Time in Pain/Day ❒ <1 hour ❒ 1-4 hours ❒ 4-8 hours ❒ Anytime not lying down ❒ 24 hours

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PAST HEALTH HISTORY *Please list dates and conditions*

Surgeries: _____

_____

Injuries/accidents/falls/fractures: _____

_____

Hospitalization: _____

Adult/childhood illnesses: _____

Allergies: _____

Current medications: _____

Family health problems/dysfunction grand/parents/siblings: _____

_____

Date of most recent medical care: _____ Reason: _____

Date of most recent chiropractic care: _____ Reason: _____

Previous diagnostic tests, x-rays and results: _____

Previous treatments/other health problems: _____

SYSTEMS REVIEW Please mark appropriate box if you have experienced in the last 12 months:

General: ❒ recent weight change ↑ ↓ ❒ weakness/fatigue ❒ fever ❒ chills ❒ night sweats

EENT: ❒ tinnitus (ringing ears) **R L** ❒ hearing loss ❒ vertigo (whirling) ❒ dizziness ❒ diplopia (double vision) ❒ blurred vision ❒ tunnel vision ❒ rhinitis (sinus infections/colds) ❒ throat hoarseness ❒ speech difficulties

Muscskel: ❒ joint swelling ❒ cramps ❒ arthritis RA OA Gout: ❒ right ❒ left

CRS: ❒ palpitation ❒ chest pain ❒ cough ❒ difficulty breathing ❒ hemoptysis (cough up blood)

GI: ❒ loss of appetite ❒ bowel/bladder problems ❒ bloody stool ❒ nausea or vomiting

GU: ❒ frequency ❒ burning ❒ hematuria (bloody urine) ❒ sexual dysfunction ❒ abnormal menses

CNS: ❒ headaches ❒ seizures ❒ fainting spells ❒ memory problems ❒ pallor/cyanosis ❒ sweating ❒ reaction to hot/cold

Endocrine: ❒ thyroid (hypo/hyper) ❒ diabetes ❒ excessive thirst/hunger

Vascular: ❒ diabetes ❒ anemia ❒ temperature changes (hot/cold) ❒ color changes (blue/white) ❒ arms/hands **R L** ❒ legs/feet **R L**

Psychiatric: ❒ depression ❒ nervous ❒ anxious ❒ irritable/moody ❒ crying spells ❒ insomnia

PERSONAL / SOCIAL HISTORY

Exercise you do and how often: _____

Marital status: M S W D Married # ____ times Spouse occupation: _____ Children s ages: _____

Parents: ❒ Married ❒ Divorced Parents education/occupation: _____

Level of your education: ❒ Less than high school ❒ HS diploma/GED ❒ Some college ❒ College degree: _____

Description of job: _____

Hobbies: _____

AMOUNT YOU CONSUME:	None	Minimal	Moderate	Much
Junk food/fast food	❒	❒	❒	❒
Sweets, sugar, soda	❒	❒	❒	❒
Coffee, tea, cola: cups/day_____	❒	❒	❒	❒
Alcohol: Drink/Day _____	❒	❒	❒	❒
Meats, beef, animal fats	❒	❒	❒	❒
Tobacco: Packs/day _____	❒	❒	❒	❒

DIET:

a. Drink enough water (8-12 cups/day)? ❒ Yes ❒ No

b. Eat enough vegetables? ❒ Yes ❒ No

c. Eat raw foods like salads, fruits, etc.? ❒ Yes ❒ No

d. Eat whole grains/flour products? ❒ Yes ❒ No

e. Vitamins: (list) _____

_____

Please indicate below why you are choosing chiropractic care:

❒ 1. I want to utilize chiropractic care for the relief of my pain or symptoms only.

❒ 2. I want a program designed for a healthy spine and nervous system.

❒ 3. I would like the doctor to decide the most appropriate care for me.

Current personal health goals: _____

_____

Signed _____ Date _____