**Faulkner Chiropractic and Acupuncture**
**Patient History**

Date: _____
Name: _____ Referred By: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone #: _____ Birthdate: _____ Age: ___ Sex: ___ Marital Status: ___ # of Children: ___
Occupation: _____ Employer: _____ Work Phone #: _____
Social Security #: _____ Email address: _____

**PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is confidential):**
Major Complaint: _____
_____
How long have you had this condition: _____ Date Began: _____
Have you had a similar condition before? Yes ( ) No ( ) When? _____
When did you last see a chiropractor? _____ Dr. _____
Why did you see this chiropractor? _____ Were you helped? _____
What spinal maintenance programs were you given to follow to maximize the future stability of your spine? _____
Did you follow it? _____ If not, why? _____
Why are you changing chiropractors? _____

**PAST (O) OR PRESENT (X) CONDITIONS:**

___ Fractured Bones
___ Auto Accidents
(a)___ 0-1 years ago
(b)___ 1-5 years ago
(c)___ More than 5 yrs ago
___ Other Accidents/Falls
___ Knocked Unconscious
___ Back Curvature
___ Mental or Emotional Disorders
___ Arthritis
___ Diabetes
___ Swollen or Painful Joints
___ Convulsions/Epilepsy
___ Skin Problems
___ Itching
___ Bruise Easily
___ Cancer
___ Frequent Colds/Flu's
___ Nervous
___ Tension
___ Depressed
___ Irritable
___ Anemia
___ Excess Sweating
___ Tremors
___ Light Bothers Eyes
___ Allergy
___ Sinus Problems
___ Light Headed Upon Rising
___ Under Stress
___ Crave Sweets and/or Salt
___ Eating Disorders
___ Trouble Sleeping
___ Trouble Concentrating
___ Loss of Memory

___ Learning Disability
___ Mistake sidedness (R from L)
___ Stutter
___ Dyslexia
___ Mood Changes
___ Lose Temper Easily
___ Headache
___ Neck pain or stiffness R, L
___ Numbness, tingling, or pain in Arms, hands, fingers, R, L.
___ Jaw pain or click (T.M.J.) R, L.
___ Head seems too heavy
___ Head and Shoulders feel tired
___ Difficulty in excessive (standing, walking, sitting, riding, bending, lifting, twisting, household duties)
___ Shoulder pain R, L
___ Dizziness
___ Ringing in ears R, L
___ Hearing loss R, L
___ Fainting
___ Loss of balance
___ Blurred or double vision R, L
___ Upper back pain or stiffness
___ Mid back pain or stiffness
___ Lower back pain or stiffness
___ Numbness, tingling or pain in Buttocks, thighs, legs, feet, toes
___ Pain with cough, sneeze or strain at stools
___ Hip pain R, L
___ Foot trouble R, L
___ Chest pain
___ Lung problems

___ Difficult Breathing
___ Wheezing
___ Heart Problems
___ Stroke
___ High or Low Blood Pressure
___ Varicose Veins
___ Liver Trouble
___ Gall Bladder Trouble
___ Digestive problems
___ Excessive Gas
___ Belching/Bloating after meals
___ Heartburn
___ Ulcers
___ Diarrhea/Constipation
___ Colon Trouble
___ Hemorrhoids
___ Prostate problems
___ Impotence
___ Kidney Trouble
___ Kidney Stones
___ Frequent urination
___ Discharge
___ Menstrual problems/PMS
___ Menopausal problems
___ Breast lumps, soreness, Discharge
___ Pregnant (now)
___ Bedwetting
___ Ear infections
___ Hepatitis
___ Venereal Disease
___ AIDS/HIV
___ Other
_____
_____

What is your health philosophy? (What should you do to stay healthy?) _____

_____

_____

How do you want us to handle your problem?

____ Temporary Relief (Help the symptom but do not fix the cause of the problem)

____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

Why did you come to our clinic and what are your expectations of us? _____

_____

_____

What are your favorite hobbies or activities to do now? _____

_____

Are your current problems affecting these activities or hobbies? _____

What activities are you looking forward to doing in retirement? _____

_____

Who would you like to be doing these activities with? _____

On a scale of 1-10 (10 being the most, and 1 being the least),

_____ How committed are you to being at your maximum health potential?

_____ How important is it for your family to be at their optimum health potential?

_____ How committed are you to preventing arthritis and maximizing your spinal stability?

What surgeries have you had? _____

_____

List drugs you now take (prescription and non-prescription):_____

_____

Name other doctors you have seen for this condition: what was done, and for how long?

_____

_____

_____

Are you currently wearing: Heel lifts ( ) Arch Supports ( )

PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Faulkner Chiropractic and Acupuncture will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Faulkner Chiropractic and Acupuncture will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. I hereby give my permission to be examined and treated by the Faulkner Chiropractic and Acupuncture office.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____