

Dr. Suzanne Chester, DC, DABCI

CONFIDENTIAL PATIENT INFORMATION

All patient information is confidential and is released to others only with your approval. Answering all questions completely helps the doctor determine the extent of your health problems and verifies that they have a chiropractic solution. If we do not sincerely believe that we can help you; we will help you find someone who can.

Name _____ Birthdate _____ Date _____

Heard about our office through _____

List your primary reason for your appointment – Chiropractic, Acupuncture, Holistic Primary Care

List your health care concerns or symptoms:

Over the past _____ (days – weeks – months – years)

My health problems have been:

- ☐ Rapidly Getting worse ☐ Staying About the Same
☐ Gradually Getting Worse ☐ Getting Better

Comments _____

I would describe my pain as (circle as many as apply):

Constant	Frequent	Intermittent	Occasional
Very Severe	Severe	Moderate	Mild
Stabbing	Sharp	Dull	Aching
Other _____			

Have you ever had chiropractic care before? **Y** **N**

List other doctors consulted for these health problems:

Name _____

Diagnosis _____

How long did you see the Doctor" _____

Results _____

When Consulted: _____

Treatment _____

How frequently? _____

Name _____

Diagnosis _____

How long did you see the Doctor" _____

Results _____

When Consulted: _____

Treatment _____

How frequently? _____

Present Family Doctor? _____

Date of last physical examination? _____

Date of last blood work? _____

By Doctor? _____

Have you had any recent x-rays, MRI's or other diagnostic test? _____

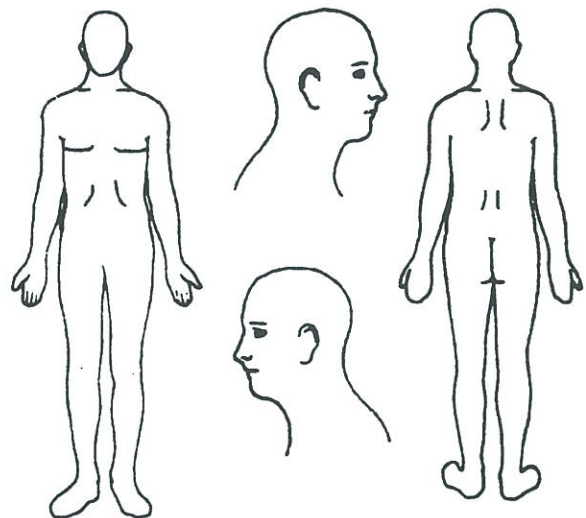
What surgeries have you had?

Type / When / Doctor / Remarks _____

List all previous serious accidents, serious falls, all broken bones (auto, work, home, leisure, sports, other - circle one)

What / When / Symptoms / Treatment / Results _____

Please mark your areas of pain on the figures below.



List all medications and/or diet supplements you take and the reason needed

What / Frequency / Doctors / Side Effects / Remarks _____

Environment**Work** - (Please circle appropriate answer)

Seated / Standing – Work Bench / Desk / Counter / Other _____

Job requires – Physical exertion / Lifting / Bending / Stooping / Twisting / Turning / Carrying / Walking / Standing / Other _____

Chair – Executive / Steno / Bench / Stool / Folding / Other _____ Shoes – High Heels / Boots / Other _____

Leisure

Sedentary Activities – Standing / Seated / Lying – TV / Reading / Card Games / Sewing / Other (Please describe) _____

Strenuous Activities – Exercise - Type / Frequency / Length of Time _____

Sports – Type / Frequency / Length of Time (if you have discontinued sports or strenuous activities, why the change?) _____

Do you physically exert yourself – Frequently / Occasionally / Rarely / Never - Describe how _____

What else should the doctor know about your health?Sleep _____ hrs/night Do you sleep on your ☐ Back ☐ Side ☐ Stomach Non-job Exercise _____ hrs/weekAge of Mattress _____ or waterbed _____ Is your bed comfortable? ☐ No ☐ YesWhat kind of pillow do you use? ☐ Thick ☐ Medium ☐ Thin ☐ None ☐ SupportDo you wear ☐ Heel Lifts ☐ Shoe Lifts ☐ Arch Supports ☐ Orthotics, describe _____**CONDITIONS**

Check (✓) conditions you have or have had in the past

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tumors / Growths |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hernia | <input type="checkbox"/> Polio | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatoid Arthritis | |

GENERAL SYMPTOMS

Check (✓) symptoms you currently have or have had in the past year

GENERAL

- ☐ Bruise Easily
- ☐ Chills
- ☐ Dental Problems
- ☐ Depression
- ☐ Difficulty Sleeping
- ☐ Dizziness

- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Loss of Weight

- ☐ Nervousness
 - ☐ Numbness
 - ☐ Sweats
 - ☐ Tiredness
 - ☐ Weight Gain
- GENITO-URINARY**
- ☐ Blood in Urine

- ☐ Frequent Urination
 - ☐ Lack of Bladder Control
 - ☐ Painful Urination
- GASTROINTESTINAL**
- ☐ Appetite Poor
 - ☐ Bloating
 - ☐ Bowel Changes

- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation

- ☐ Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earaches
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems

- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN

- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sore That Won't Heal

MEN only

- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Other _____

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding Between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Other _____

Date of Last Menstrual Period? _____

Date of Last Pap Smear? _____

Have you had a Mammogram? _____

Are you Pregnant? _____

Number of Children? _____

NECK, BACK & EXTREMITIES

Check (✓) symptoms you currently have or have had in the past year

NECK

- ☐ Pain
- ☐ Stiffness
- ☐ Weakness
- ☐ Pinched Nerve
- ☐ Feels out of Place
- ☐ Muscle Spasms
- ☐ Grinding Sounds
- ☐ Popping Sounds

SHOULDERS

- | | | |
|---|----------------------------|----------------------------|
| | RIGHT | LEFT |
| <input type="checkbox"/> Pain in Shoulder Joint | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain Across Shoulders | | |
| <input type="checkbox"/> Can't Raise Arm | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Above Shoulder Level | | |
| <input type="checkbox"/> Over Head | | |

☐ Tension

- | | | |
|--|----------------------------|----------------------------|
| <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> R | <input type="checkbox"/> L |
|--|----------------------------|----------------------------|

MID-BACK

- ☐ Pain
- ☐ Stiffness
- ☐ Pain between Should Blades

- ☐ Pain from Front to Back

- ☐ Muscle Spasms

ARMS & HANDS

- | | | |
|--|----------------------------|----------------------------|
| | RIGHT | LEFT |
| <input type="checkbox"/> Pain in Upper Arm | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in Elbow | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in Forearm | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in Hand | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in Fingers | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pins & Needles in Arm | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pins & Needles in Fingers | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Numbness in Arm | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Weakness of Arm | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Weakness of Hand | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Cold Hands | <input type="checkbox"/> R | <input type="checkbox"/> L |

LOW BACK

- ☐ Pain
- ☐ Stiffness
- ☐ Weakness
- ☐ Pinched Nerve
- ☐ Feels Out of Place

- ☐ Muscle Spasms

HIPS, LEGS & FEET

- | | | |
|--|----------------------------|----------------------------|
| | RIGHT | LEFT |
| <input type="checkbox"/> Pain in Buttocks | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in Hip Joint | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain Down Leg | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in Knee | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in Ankle | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Pain in Foot | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Weakness of Leg | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Weakness of Knee | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> R | <input type="checkbox"/> L |

OTHER SYMPTOMS

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature

Date

