Healthy Back Chiropractic
1707 Lansing Ave. NE Salem, OR 97301

Patient Name _____ Account Number _____ DOB _____

Health History

Chief Complaint
History of Current Illness:
Location (Where is the pain/problem?)

Quality (EX: normal/abnormal color, activity, etc.)

Severity (How severe is the pain/problem on a scale of 1-5, with 5 being the most severe?)

Duration (How long have you had this pain/problem? When did it start?)

Timing (Does the pain/problem occur at a specific time?)

Context (Where were you at the onset of this pain/problem?)

Associated signs/symptoms (What other associated problems have you been having?)

Modifying factors (What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History
Have you ever had the following: (circle "yes" or "no", leave blank ifyou are uncertain)

Measles	YES	NO	Back Trouble	YES	NO
Mumps	YES	NO	High Blood Pressure	YES	NO
Chickene Pox	YES	NO	Low Blood Pressure	YES	NO
Whooping Cough	YES	NO	Hemorrhoids	YES	NO
Scarlet Fever	YES	NO	Asthma	YES	NO
Diphtheria	YES	NO	Hives or Eczema	YES	NO
Small Pox	YES	NO	AIDS & HIV	YES	NO
Pneumonia	YES	NO	Infectious Mono	YES	NO
Rheumatic Fever	YES	NO	Bronchitis	YES	NO
Arthritis	YES	NO	Mitral Valve Prolapse	YES	NO
Venereal Disease	YES	NO	Stroke	YES	NO
Anemia	YES	NO	Hepatitis	YES	NO
Bladder Infection	YES	NO	Ulcer	YES	NO
Epilepsy	YES	NO	Kidney Disease	YES	NO
Migarine Headaches	YES	NO	Thyroid Disease	YES	NO
Tuberculosis	YES	NO	Bleeding Tendency	YES	NO
Diabetes	YES	NO	Other Disease (please list)		
Cancer	YES	NO			
Polio	YES	NO			
Glaucoma	YES	NO			
Hernia	YES	NO			
Blood or Plasma Transfusion	YES	NO	Date of Last Chest X-Ray		

Doctor Signature _____ Date _____

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Previous Hospitalizations/Surgeries/Serious Illnesses

Condition	When	Hospital, City, State

Medication (include non-prescription)

_____

_____

Have you ever taken Fen-Phen/ Redux? YES NO

Patient Social History

Marital Status	Single	Married	Separated	Divorced	Widowed
Use of Alcohol	Never	Rarely	Moderate	Daily	
Use of Tobacco	Never	Rarely	Moderate	Daily	
Use of Drugs	Never	Type/Frequency			

Execessive exposure at home or at work: Fumes Dust Solvents Airborne Particles Noise

Family Medical History

	Age	Disease	If Diseases, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Indicate which of the below you have experienced in the last 1-2 months.

1=Never 2=Rarely 3=Occassionally 4=Frequently 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1	2	3	4	5
Stuffy Nose	1	2	3	4	5
Hay Fever	1	2	3	4	5
Sore Throat	1	2	3	4	5
Chronic Cough	1	2	3	4	5
Chest Congestion	1	2	3	4	5
Frequent Sneezing	1	2	3	4	5
Itchy/Watery Eyes	1	2	3	4	5
Drainage	1	2	3	4	5
Earache or Ear Infection	1	2	3	4	5
Itching	1	2	3	4	5
Hoarseness	1	2	3	4	5
Shortness of Breath	1	2	3	4	5
Wheezing	1	2	3	4	5

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Neurological					
Headaches	1	2	3	4	5
Migraines	1	2	3	4	5
Dizziness	1	2	3	4	5
Numbness	1	2	3	4	5
Tingling	1	2	3	4	5
Muscular/Skeletal					
Muscle Aches	1	2	3	4	5
Fibromyalgia	1	2	3	4	5
Arthritis	1	2	3	4	5
Joint Pain	1	2	3	4	5
Low Back Pain	1	2	3	4	5
Neck Pain	1	2	3	4	5
Wrist/Hand Pain	1	2	3	4	5
Elbow Pain	1	2	3	4	5
Shoulder Pain	1	2	3	4	5
Hip Pain	1	2	3	4	5
Knee Pain	1	2	3	4	5
Ankle/Foot Pain	1	2	3	4	5
Pain B/T Shoulder Blades	1	2	3	4	5
General					
Fatigue	1	2	3	4	5
Malaise	1	2	3	4	5
Weekness/Tiredness	1	2	3	4	5
Lightheadedness	1	2	3	4	5
Irritability	1	2	3	4	5
Constipation	1	2	3	4	5
Diarrhea	1	2	3	4	5
Feeling Foggy	1	2	3	4	5
Forgetfulness	1	2	3	4	5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient/Guardian Date

Doctor Signature _____ Date _____