Riverside Chiropractic - Hackettstown, NJ - (908) 876-8777

Health History

Name (please print clearly):_____ Date:_____
Address:_____ City:_____ State: _____ Zip:_____
E-mail Address: _____
Birth Date: _____ Age _____ SS# _____
Home Phone: (_____) _____ Work Phone: (_____) _____
Best Contact Number (_____) _____
In case of emergency, notify_____ Relationship_____
Phone (_____) _____
Name of Employer _____ Occupation: _____
Marital Status: S M D W # of children: _____
Spouse/Partner Name _____ Spouse/Partner Age _____
Financial Information: Who is responsible for this account?_____
Reason Seeking Care: Pain/Injury Related YES NO Wellness/Health Maintenance YES NO

Chief Complaint or Reason for Office Visit: _____
Specific Date and Time of Onset of Symptoms: _____
What makes your symptoms better? _____
What makes your symptoms worse?_____
Are your symptoms local or do they travel to another area? (If yes, to where?) _____
_____

Accidents: Please list ANY accidents, include dates. (car, bicycle, motorcycle, sports, slips/falls at work/home)
_____
_____
_____

Surgeries/Conditions: Please list major surgeries, broken bones or conditions, include dates.
_____
_____
_____

Medications: List prescription meds & over the counter meds you are currently taking & the dosage and purpose.
_____
_____
_____

Have you been to a chiropractor before? YES NO
Briefly describe your experience:
_____
_____

Did the last chiropractor adjust your spine? YES NO
If yes, was there a "popping" sound when they adjusted you? YES NO
How many visits to our office do you anticipate? _____

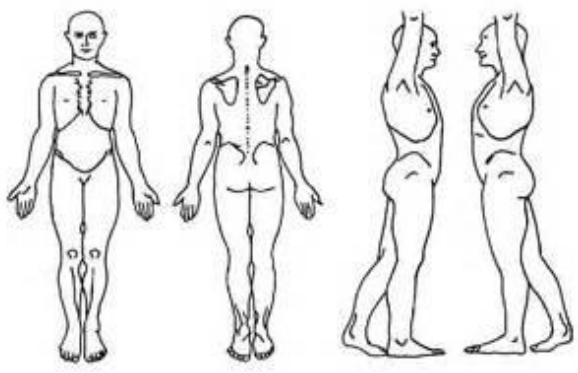
If you are here due to an injury or pain please describe what happened:

_____

_____

Please mark your areas of pain on the figures by indicating the location of pain and the symbol that best describes your discomfort.

Sharp & Stabbing	A
Dull & Achy	B
Pins & Needles	C
Numbness	D



PATIENT HISTORY REVIEW OF SYSTEMS

0 = NEVER HAD 1 = PRESENTLY HAVE 2 = PREVIOUSLY HAD

GENERAL	**MUSCULOSKELETAL**	**NEUROLOGICAL**
Recent weight gain	Arthritis	Lightheaded/Dizzy
Recent weight Loss	Rheumatoid Arthritis	Memory Loss
Fatigue	Broken Bones	Headaches
Fever	Osteoporosis/Osteopenia	Migraines
Allergies	Gout	Numbness
Loss of appetite	Scoliosis	Weakness
Chills	Spinal Trauma	Stroke
Cancer of Any Kind	Joint Pain (anywhere)	Tingling/Numbness
	Cramping of muscles	Fainting episodes
CARDIOVASCULAR	**RESPIRATORY**	**SKIN**
Heart Attack	Coughing	Bruise Easily
Swelling of Ankles	Coughing Up Blood	Skin Rashes
High Blood Pressure	Chronic Cough	Discolorations
Low Blood Pressure	Chest Pain	Psoriasis
Shortness of Breath	Asthma	Changes in Moles
Pain Down Left Arm	Pneumonia	Sores
Profuse sweating	Bronchitis	Scars
High Cholesterol	Tuberculosis	Itching
EYES, EARS NOSE &	**GASTROINTESTINAL**	**GENITOURINARY**
Blurred Vision	Gall Bladder Problems	Painful Urination
Double Vision	Liver Problems	Blood in Urine
Ear pain	Pain over Stomach	Frequent Urination
Hoarseness	Ulcers	Kidney Infection
Nose Bleeds	Colitis	Kidney Stones
Glaucoma	Hiatal Hernia	Incontinence
Dental problems	Blood in Stool	

Other/Explanations:_____

_____

Health Survey

Do you smoke? YES NO If yes, how much per day/week? _____
Do you drink alcohol? YES NO If yes, how much per day/week? _____
Do you exercise? YES NO If yes, how often and what type _____
Do you drink caffeine? YES NO If yes, how much per day/week? _____
Do you take any nutrition supplements currently? YES NO If yes, please list including dosage and brand if known

_____
_____
_____

How is your stress level? LOW MODERATE HIGH
How would you rate your overall current health? (circle one) Poor Fair Average Good Excellent
Do you want to live a long & healthy life? Yes No
If you answered yes above, how much time per day outside our office are you willing to commit to this goal?
_____hours _____minutes

Please score yourself from 1 to 10 below in each health category and then indicate if you are interested in receiving help in these areas. You can select as many or as few as you like.

Musculoskeletal pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain)
I would like help and/or info on decreasing my pain: Yes No

Diet and nutrition: 1 2 3 4 5 6 7 8 9 10 (1 horrible diet, 10 excellent diet)
I would like help and/or info on improving my diet and nutrition: Yes No

Exercise program: 1 2 3 4 5 6 7 8 9 10 (1 horrible exercise habits, 10 excellent exercise habits)
I would like help and/or info on exercise: Yes No

Ability to sleep well: 1 2 3 4 5 6 7 8 9 10 (1 horrible sleeper, 10 excellent sleeper)
I would like help and/or info on getting a good nights sleep: Yes No

Stress level:1 2 3 4 5 6 7 8 9 10 (1 no stress at all, 10 extreme stress)
I would like help and/or info on decreasing my stress: Yes No

Headache frequency: 1 2 3 4 5 6 7 8 9 10 (1 constant headaches, 10 never)
I would like help and/or info on decreasing my headaches: Yes No

Pharmaceutical drug intake: 1 2 3 4 5 6 7 8 9 10 (1 daily intake, 10 never)
I would like help and/or info on alternative solutions: Yes No

Energy Level:1 2 3 4 5 6 7 8 9 10 (1 no energy at all, 10 endless energy) I would like help and/or info on increasing my energy level: Yes No

Other areas of health that you may need help:

_____
_____

Sign:_____ Date:_____