

MEDICARE PERSONAL HISTORY

Name: _____ Date: _____

Address: _____ Social Security Number: _____

City: _____ State: _____ Zip Code: _____ Sex M F

Home Phone() _____ Business Phone() _____

Cell Phone () _____ Birthday _____ Age _____

Email address _____ Emergency contact _____

Occupation: _____ Business/Employer: _____

Referred by: _____

Marital status: M S W D Name of Spouse _____

Describe health of spouse _____

Are you insured: Y N Primary Company name _____

Secondary Company name _____

1. Chief complaint (reason you are here): _____

2. How did your problem begin? _____

↑ Auto accident ↑Work related accident ↑Other type of accident

↑ Gradual Sudden Cumulative Trauma Repetitive Stress No specific reason

3. How long have you had this problem? _____

4. How would you describe your pain?

Dull Sharp Throbbing Burning Deep Ache Tingling Stabbing

Cramping Spasm Tightness Numb Stiff Radiating

5. How would you rate the intensity of your pain right now? (Circle a number)

0 1 2 3 4 5 6 7 8 9 10
(minimal) (mild) (moderate) (severe) (unbearable)

6. How frequent is the problem?

Constant daily _____ times per day week month year

7. What percent of the day is the pain present during your waking hours? (circle one)

↑0%↑10%↑20%↑30%↑40%↑50%↑60%↑70%↑80%↑90%↑100%

8. Since your problem began, is your pain:

↑Getting better ↑Getting worse ↑Staying the same

9. What makes your problem better?

Sitting Standing Lying Heat Movement No movement Ice Topical analgesic

Medication Over the counter medication Stretching Exercise Other-

↑

10. What makes your problem worse?

Sitting Standing Walking Bending Stooping Lifting Sleeping Sneezing Coughing

Straining Reaching Twisting Movement Lying Driving Stairs Typing Exercise

Household chores Other-

↑

11. Is your problem affecting your ability to work or do other routine daily activities?

- ↑ No effect
- ↑ Have some restrictions but can function
- Need some assistance with activities ↑
- Cannot function without assistance
- Cannot work
- Totally disabled

12. What prescriptions or over-the-counter medications are you taking?

Medication

Reason for Taking

_____	_____
_____	_____
_____	_____

13A. Were you previously treated for this condition? ↑Yes ↑No *If yes, please describe by whom*
MD/DO Physical therapist ↑Acupuncturist (for Chiropractor see number 14)

13B. First Doctor's or Practitioner's Name _____

Address _____

Diagnosis - what did they say was/is wrong _____

Treatment/medication provided _____

Date of first treatment _____ last treatment _____ Did/does it help? Y N

Second Doctor's or Practitioner's Name _____

Address _____

Diagnosis - what did they say was/is wrong _____

Treatment/medication provided _____

Date of first treatment _____ last treatment _____ Did/does it help? Y N

14. Have you been treated by a Chiropractor for this or another problem? Yes No

Chiropractor's name and address _____

Reason for treatment _____

Date of first treatment _____ date of last treatment _____

Number of treatments ____ How often did you see the Doctor _____ Did it help? Y N

15. Please list any Doctor's you have seen in the last year or are seeing now _____

16. Have you been treated for any health conditions in the last year? ___Yes ___No If Yes, explain: _____

17. Have you had any car accidents YES NO _____
or other accidents or falls: YES NO _____

18. Any ER or hospitalization _____

19. Any surgery: Appendectomy Tonsillectomy Gall Bladder Hernia Spinal
Other surgery or Broken Bones _____

20. Please list any x-rays, MRIs, CT scans, bone density, bone scans that you have had:

Area of body	Type of Test	Where was it done?	When	Results/do you have the report

21. What is your physical activity at work?

↑ Mostly sitting ↑Light manual ↑Moderate manual ↑Heavy manual

22. Do you exercise?

↑No regular exercise ↑1-2 times/week ↑3-4 times/week ↑5-7 times/week
↑Cardiovascular ↑Stretching ↑Weight Machine ↑Free Weights
↑Sports _____

23. What is your general stress level?

↑No stress ↑Minimal stress ↑Moderate Stress ↑Greatly stressed

24. Do you take vitamins, herbs or nutritional supplements?

↑No ↑Yes If yes, what do you take? _____

25. Do your have any other health problems? Yes No What are they? (use back if needed)

26. List any major illnesses you have had with approximate dates: _____

Name _____ Date _____

ASIDE FROM YOUR MAJOR COMPLAINT ABOVE; WHICH OF THE FOLLOWING DO YOU EXPERIENCE?

	PAIN	DISCOMFORT	TENDERNES	TIGHTNESS	MUSCLE SPASM	LACK OF MOTION	NUMB	TINGLING	PINS & NEEDLES	WEAKNESS	INFLAMMATION
HEAD	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
NECK	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
UPPER BACK	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
MID BACK	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
RIBS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
LOW BACK	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
HIPS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
UPPER LEGS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
KNEES	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
LOWER LEGS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
ANKLES	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
FEET/TOES	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
SHOULDERS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
ARMS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
ELBOWS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
FOREARMS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
WRISTS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
HANDS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
FINGERS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L

NOTE On the next page is a list of various symptoms, conditions, etc. Some may seem unrelated to the purpose of your appointment. However, these questions are important and must be answered carefully. *Thank-you.*

ON THE NEXT PAGE:

MARK ANY OF THE CONDITIONS OR PROBLEMS THAT YOU HAVE **NOW** WITH AN **“N”**
 MARK ANY OF THE CONDITIONS YOU HAD IN THE **PAST** WITH A **“P”**

<u>MS</u>	<u>GI</u>	<u>__Wheezing</u>
<u>PAIN, NUMB or STIFF</u>	<u>__Diabetes</u>	<u>__Asthma</u>
<u>__Headache</u>	<u>__Colonoscopy</u>	<u>__Emphysema</u>
<u>__Jaw , jaw clicking</u>	<u>__Difficult chewing</u>	<u>__Pleurisy</u>
<u>__Neck</u>	<u>__Clicking jaw</u>	<u>__Pneumonia</u>
<u>__Neck Disk Degeneration</u>	<u>__Weight loss/gain</u>	<u>__Whooping Cough</u>
<u>__Neck Disk Herniation (slipped)</u>	<u>__Thirsty often</u>	<u>__Tuberculosis</u>
<u>__Neck Disk Bulge</u>	<u>__Colitis</u>	<u><u>EENT</u></u>
<u>__Shoulder(s)</u>	<u>__Colon Cancer</u>	<u>__Allergies</u>
<u>__Carpal Tunnel</u>	<u>__Diverticulitis</u>	<u>__Tonsillitis</u>
<u>__Arms(s)</u>	<u>__Constipation</u>	<u>__Jaw Pain/Clicking</u>
<u>__Elbow(s)</u>	<u>__Diarrhea</u>	<u>__Ear Ringing</u>
<u>__Forearm(s)</u>	<u>__Digestion trouble</u>	<u>__Poor Hearing</u>
<u>__Wrist(s)</u>	<u>__Heartburn</u>	<u>__Swollen Glands</u>
<u>__Hand(s)</u>	<u>__GERD/Acid Reflux</u>	<u>__Poor Vision</u>
<u>__Finger(s)</u>	<u>__Stomach cramps</u>	<u>__Eye Pain/Strain</u>
<u>__Upper back</u>	<u>__Appendicitis</u>	<u>__Hay Fever</u>
<u>__Between Shoulder Blades</u>	<u>__Excessive hunger</u>	<u>__Rheumatic Fever</u>
<u>__Midback (below shoulder blades)</u>	<u>__Gall Bladder pain</u>	<u>__Scarlet Fever</u>
<u>__Low back</u>	<u>__Stuffed Nose</u>	<u>__Diphtheria</u>
<u>__LB Disk Degeneration</u>	<u>__Nose Bleed</u>	<u>__Typhoid Fever</u>
<u>__LB Disk Herniation (slipped)</u>	<u>__Sinus Infections</u>	<u>__Polio</u>
<u>__LB Disk Bulge</u>	<u>__Sore Throat</u>	<u>__Hiv/Aids</u>
<u>__Sciatica</u>	<u>__Dental Problems</u>	<u>__Anemia</u>
<u>__Buttock(s)</u>	<u><u>CV</u></u>	<u>__Measles</u>
<u>__Hip(s)</u>	<u>__Heart Disease</u>	<u>__Mumps</u>
<u>__Upper Leg(s)</u>	<u>__Heart Attack/Surgery</u>	<u>__Small Pox</u>
<u>__Knee(s)</u>	<u>__Chest Pain</u>	<u>__Chicken Pox</u>
<u>__Lower Leg(s)</u>	<u>__Poor Circulation</u>	<u>__Cancer</u>
<u>__Ankle(s)</u>	<u>__Irregular Heartbeat</u>	<u>__Goiter</u>
<u>__Foot, Feet</u>	<u>__Ankle Swelling</u>	<u>__Influenza</u>
<u>__Arthritis</u>	<u>__Short Breath</u>	<u>__Alcoholism/Drug Abuse</u>
<u>__Bursitis</u>	<u>__Varicose Veins</u>	
<u>__Hernia</u>	<u>__Clots in arteries</u>	<u>__Sexually-transmitted disease</u>
<u>__Scoliosis</u>	<u>__High/Low Blood Pressure</u>	<u>__Venereal Disease</u>
<u>__Swollen Joints</u>	<u><u>GU</u></u>	
<u>__Walking Problems</u>	<u>__Bladder trouble</u>	<u><u>Females</u></u>
<u>__Poor Posture</u>	<u>__Blood in Urine</u>	<u>__Hysterectomy/other surgery</u>
<u><u>NS</u></u>	<u>__Frequent Urination</u>	<u>__Menstrual Irregularity</u>
<u>__Convulsions</u>	<u>__Inability to Control Bladder</u>	<u>__Menstrual Cramps</u>
<u>__Paralysis</u>	<u>__Kidney Infection / Stone</u>	<u>__Menstrual Backache</u>
<u>__Tremors</u>	<u>__Painful Urination</u>	<u>__Breast Pain/Lumps</u>
<u>__Sweats</u>	<u>__Diminished Urination</u>	<u>__Mammography</u>
<u>__Numbness</u>	<u>__Discolored Urine</u>	<u>__Vaginal Pain/Infection</u>
<u>__Stroke</u>	<u>__Jaundice</u>	<u>__Pregnant or may be</u>
<u>__Neuralgia</u>	<u>__Liver Trouble</u>	<u>__Post Menopause</u>
<u>__Forgetfulness</u>	<u>__Nausea</u>	<u><u>Males</u></u>
<u>__Confusion</u>	<u>__Stomach Pain</u>	<u>__Swollen Prostate</u>
<u>__Nervousness</u>	<u>__Poor Appetite</u>	<u>__Prostatic Cancer</u>
<u>__Depression</u>	<u>__Vomiting</u>	<u>__Testicular Cancer</u>
<u>__Antidepressant use</u>	<u>__Vomiting Blood</u>	<u>__Surgery</u>
<u>__Fainting</u>	<u>__Discolored stools</u>	
<u>__Dizziness</u>	<u><u>RESP</u></u>	
<u>__Fatigue</u>	<u>__Smoke Cigarettes</u>	
<u>__Loss of Sleep</u>	<u>__Persistent Cough</u>	
<u>__Epilepsy</u>	<u>__Lung Cancer</u>	
<u>__Multiple sclerosis</u>	<u>__Hard to Breathe</u>	
<u>__Cold/tingling arms, hands, fingers</u>	<u>__Spitting up Blood</u>	
<u>__Cold/tingling legs, feet, toes</u>	<u>__Spitting up Phlegm</u>	

Past or Present Symptoms, Conditions

Please check the box indicating whether you have or have had any of the following at any time.



Symptoms/Conditions	Past	Present	
Rheumatoid arthritis			
Ankylosing spondylitis			
Bone fractures			
Malignancy of the spine			
Infection of the bones or joints			
Myelopathy			
Cauda Equina syndrome			
Carotid artery problems			
Aneurysm			
Instability of joints			
Benign tumors of the spine			
Osteoporosis			
Bleeding disorders			
Nerve problems			
Anticoagulants/blood thinning therapy			
Dizziness			
Drop Attacks			
Double vision			
Difficulty speaking			
Difficulty swallowing			
Nausea			
Numbness			
Nystagmus			
Neck pain			
Jaw pain			
Headaches			
Fainting spells			
High blood pressure			
Stroke			
Transient ischemic attacks			

27. Social and Occupational History

Level of education _____

Job description _____

Work schedule _____

Recreational activities _____

Amount of exercise: _____ Alcohol use: _____

Tobacco use: _____ Drug use: _____

Coffee use: _____

Any household pets or other animals you or family members are in close contact with:

28. Family History

Relationship	Health Problem(s)- such as heart disease, diabetes, arthritis, osteoporosis, cancer etc.
Father	
Mother	
Brother	
Sister	

29. Is there anything else you wish to tell the Doctor? _____

30. What can we do to make you happier? _____

Please read and sign the following certification:

I certify that the information I have given on the preceding pages is true and complete. I have not withheld any information relative to my health or any condition, problem or symptom. I hereby authorize Eickhoff Chiropractic and Nutrition Family Wellness Center, its Doctors and Staff, to provide me with care in accordance with this State's statutes.

Patient's (Parent/Guardian) Signature

Date

THANK-YOU!

Dr. Eickhoff