EICKHOFF CHIROPRACTIC AND NUTRITION FAMILY WELLNESS CENTER
Dr. William T. Eickhoff D.C.
1011 Clifton Avenue 973-470-0687 Clifton, N.J. 07013

# NUTRITION 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 __________________________________________________

1. Chief complaint (reason you are here): ___________________________________________
______________________________________________________________________________

2. How did your problem begin? _________________________________________________

3. How long have you had this problem? ____________________________________________

4. How frequent is the problem?
Constant daily _____ times per day week month year

5. Since your problem began, is it:
↑Getting better ↑Getting worse ↑Staying the same

6. What makes your problem better? ________________________________________________
______________________________________________________________________________

7. What makes your problem worse? _________________________________________________
______________________________________________________________________________

8. 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

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

| Medication | Reason for Taking |
| --- | --- |
| ____________________ | ____________________ |
| ____________________ | ____________________ |
| ____________________ | ____________________ |

10A. Were you previously treated for this condition? Yes No *If yes, please describe by whom*
MD/DO Physical therapist Acupuncturist (for Chiropractor see number 11)

10B. 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

11. 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

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

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

14. Have you had any car accidents YES NO ____________________
or other accidents or falls: YES No ____________________

15. Any ER or hospitalization ____________________

16. Any surgery: Appendectomy Tonsillectomy Gall Bladder Hernia Spinal
Other surgery or Broken Bones ____________________________________________

17. 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 |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

18. What is your physical activity at work?
↑ Mostly sitting ↑Light manual ↑Moderate manual ↑Heavy manual

19. 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__________________________________________________

20. What is your general stress level?
↑No stress ↑Minimal stress ↑Moderate Stress ↑Greatly stressed

21. Do you take vitamins, herbs or nutritional supplements?
↑No ↑Yes If yes, what do you take? ___________________________________
_______________________________________________________________

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

23. List any major illnesses you have had with approximate dates: __________________
_______________________________________________________________

***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"**

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

Name___________________________________________Date_______________

WHICH OF THE FOLLOWING DO YOU EXPERIENCE?

| | PAIN | DISCOMFORT | TENDERNESS | 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.*

Name________________________________________Date_________________________

24. 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:

___________________________________________________________________________

25. Family History

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

26. Is there anything else you wish to tell the Doctor?_________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

27. What can we do to make you happier? ____________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

28. 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*