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

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	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.*

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"**

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

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