ADVANCED CHIROPRACTIC SPECIALISTS

Confidential Patient History

Patient Name: _____ Pt. No: _____ Date: _____

PAST MEDICAL/CHIROPRACTIC HISTORY

Hospitalized/Surgeries (yes/no): _____

Accidents (Auto/Falls/Work): _____

Family History: _____

Prior Chiropractic Care: _____

Patients Please Answer Questions Below

Headaches (yes/no) (now/ever): _____
Dizziness (yes/no) (now/ever): _____
Blurred Vision (yes/no) (now/ever): _____
Depression (yes/no) (now/ever):_____
Nervousness (yes/no) (now/ever):_____
Loss of Concentration (yes/no) (now/ever):_____
Difficulty Sleeping (yes/no) (now/ever):_____
Fatigue (yes/no) (now/ever): _____
Tired A.M. (yes/no) (now/ever):_____
Buzz/Ring in Ear (yes/no) (now/ever):_____
Run Down (yes/no) (now/ever):_____
Fainting (yes/no) (now/ever):_____
Palpitation (yes/no) (now/ever):_____
Head (yes/no) (now/ever):_____
Sinus (yes/no) (now/ever):_____
Neck Pain/Stiff(yes/no) (now/ever): _____
Shoulder Prob.(yes/no) (now/ever):_____

Arm Pain (R/L) (yes/no) (now/ever):_____
Upper Back (yes/no) (now/ever):_____
Mid Back (yes/no) (now/ever):_____
Chest Pain (yes/no) (now/ever):_____
Lung (yes/no) (now/ever):_____
Heart (yes/no) (now/ever):_____
Stomach (yes/no) (now/ever):_____
Digestion (yes/no) (now/ever):_____
Bladder (yes/no) (now/ever):_____
Liver (yes/no) (now/ever):_____
Kidney (yes/no) (now/ever):_____
Colon (yes/no) (now/ever):_____
Constipation (yes/no) (now/ever):_____
Low Back (yes/no) (now/ever):_____
Hip (yes/no) (now/ever):_____
Leg Pain (R/L) (yes/no) (now/ever):_____
Poor Circulation (yes/no) (now/ever):_____