PORTLAND
CHIROPRACTIC · NEUROLOGY

Account Information

If you need any assistance completing this paperwork, please ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful and educational.

CONFIDENTIAL HEALTH INFORMATION
Clinic ID: Date:

Patient Information

Last name First name MI Prefer to be called

Are you here because you were injured while working, in a motor vehicle collision, or in another accident? ☐Yes ☐No

Health Complaints

*What is your **primary** complaint?*_____
*How long have you been experiencing this primary complaint?*_____
*Has this progressed over that time?*_____
*Using the scale below, rate how your **primary** complaint affects your life (mark only one box)*

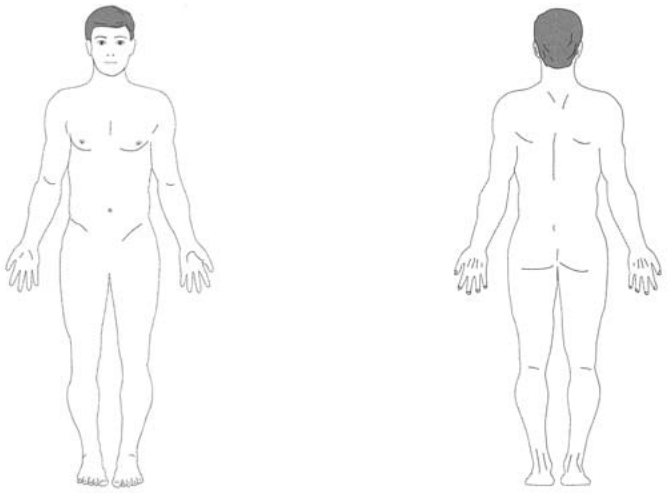
1	2	3	4	5	6	7	8	9	10
Symptoms that do not affect life in any way	Symptoms that slightly affect life	Symptoms that don't affect daily activities	Symptoms that affect daily activities	Symptoms that prevent performing daily activities	Symptoms that limit work schedule	Symptoms that prevent attending work	Symptoms that prevent work and all personal activities	Symptoms that keep me from leaving home	Symptoms that cause thoughts of suicide

Do you have any additional symptoms (musculoskeletal, neurological, or otherwise) that are related to this?
*If yes, please list:*_____
List any other health conditions/complaints you are currently experiencing on the following lines:

1) _____ 2) _____
3) _____ 4) _____

Please use the images on the right to mark the areas affected by your chief complaint and any of the associated symptoms listed above.

Include any additional descriptors or comments concerning your health complaints if necessary.



Last Name, First Initial:_____

Lifestyle & Nutritional Habits

❖ Occupational History:

Do you work? ☐ Yes ☐ No, unemployed ☐ Disability ☐ Retired

*Occupation (if working or worked previously):*_____

❖ Daily Habits:

On average how many hours of television do you watch per day?	☐ <1	☐ 1-3	☐ 3-5	☐ >5
On average, how many hours per day do you use a computer at work or home?	☐ <1	☐ 1-3	☐ 3-5	☐ >5
On average, how many hours per day do you ride in a car or other vehicle?	☐ <1	☐ 1-3	☐ 3-5	☐ >5
Do you exercise?	☐ Yes	☐ No		
If yes above, how often do you exercise?	☐ Daily	☐ 3-5x/wk	☐ 2x/wk	☐ 1x/wk
On average, how long do your workouts last?	☐ >1hr	☐ 1hr	☐ 30min	☐ <30min

What are your exercise activities? (mark all that apply)

☐ Walking	☐ Swimming	☐ Weight lifting
☐ Stretching/Flexibility	☐ Yoga/Pilates	☐ Resistance bands
☐ Running/elliptical/rowing/stairclimbing	☐ Group Exercise Class	☐ Athletics_____

Do you smoke tobacco?	☐ Yes	☐ No		
If yes to above	How often? _____		How much? _____	
Any recreational drug use	☐ Yes	☐ No		
How many servings of alcohol do you drink per week?	☐ 0	☐ 1-2	☐ 3-5	☐ >5
How many servings of coffee do you drink per week?	☐ 0	☐ 1-2	☐ 3-5	☐ >5
How many servings of soda do you drink per week?	☐ 0	☐ 1-2	☐ 3-5	☐ >5

❖ Dietary Habits:

What does your diet primarily consist of? (mark all that apply)

☐ Breads, cereals	☐ Pastas, rice	☐ Cookies, crackers, pretzels
☐ Lean protein (chicken, beef, fish)	☐ Dairy (milk, cheese, ice cream)	☐ Vegetables
☐ Processed meats (lunch meat, etc)	☐ Processed/packaged snacks/meals	☐ Fruits
☐ Candy	☐ Soda/energy & sugary drinks	☐ Coffee/tea
☐ Water		

❖ Dietary Habits cont'd:

What is your attitude about food/eating? (mark all that apply)

- ☐ Eat 3 full meals per day
- ☐ Eat less than 3 full meals per day
- ☐ Snack often throughout the day
- ☐ Eat balanced meals
- ☐ Do not eat balanced meals
- ☐ Very picky about foods
- ☐ Overeat at each meal
- ☐ Am hungry soon after each meal
- ☐ Prefer snacking over meals
- ☐ Enjoy eating
- ☐ Poor appetite for food in general

Family Health History

Mark the following conditions as they pertain to your family. Include family member (parents,siblings,children,grandparents)

Diabetes	_____	Cancer	_____
Heart problems	_____	Vascular problems (including stroke, embolism)	_____
Kidney problems	_____	Muscle diseases (myopathies)	_____
Gastrointestinal problems	_____	Nerve diseases (neuropathies)	_____
Autoimmune conditions	_____	Neurological conditions	_____
Respiratory conditions	_____	Psychiatric conditions (i.e. depression, bipolar, schizophrenia, etc)	_____
Musculoskeletal conditions	_____	Headaches	_____
Other	_____		

Does any member of your family have a condition/symptoms similar to yours? ☐ Yes ☐ No

*If yes, please explain:*_____

Medical History

Mark any of the following conditions as they pertain to you:

- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ HIV positive
- ☐ Measles
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Psychiatric Disorders
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Tuberculosis
- ☐ Venereal Infection
- ☐ Whooping Cough

Any cardiac conditions? *(if yes, please explain)*_____

Any significant illnesses or infections in your past? (if yes, please explain) _____

❖ Medical History cont'd:

Any recent illnesses or infections? (if yes, please explain) _____

Any known allergies or sensitivities? (please describe) _____

Any autoimmune conditions? (thyroid disorders, eczema, psoriasis, RA, Lupus, etc.) _____

List any broken bones or dislocations you have had (include locations, R/L) _____

Have you suffered any head injuries (including concussions)*?*	☐ Yes	Please explain:_____
Were you ever knocked unconscious?	☐ Yes	Please explain:_____
Have you ever had a lapse in memory?	☐ Yes	Please explain:_____
Have you ever had a spinal tap or injection?	☐ Yes	Please explain:_____

❖ Surgical History:

Do you have any implantable medical devices in your body? (including pacemakers, stents, plates, screws)

If yes, please explain: _____

Mark all of the following procedures as they pertain to you: *(for procedures listed in 3rd column, please describe on adjacent line)*

☐ Tonsillectomy	☐ Thyroid surgery	☐ Neurosurgery	_____
☐ Gall bladder removal	☐ Stomach surgery	☐ Spinal surgery	_____
☐ Appendectomy	☐ Rectal surgery	☐ Cardiac surgery	_____
☐ Hernia repair	☐ Abdominal surgery	☐ Orthopedic surgery	_____
☐ Breast implant surgery	☐ Tubes in ears	☐ Female surgery	_____
☐ Cesarean Section	☐ Knee/hip replacement	☐ Male Surgery	_____
		☐ Other	_____

❖ Medications, Vitamins, Supplements

Please list any *vitamins or supplements* you are currently taking:

_____ _____ _____

_____ _____ _____

Please list any *prescription or over-the-counter medications* you are currently taking and the condition for which you are taking them:

_____ _____ _____

_____ _____ _____

Injuries

❖ *List any (even minor) motor vehicle collisions (auto or otherwise), that you have been involved in as either driver or passenger, begin with most recent*

Type of collision	Injuries suffered & treatment received	Date of injury

❖ *List any job injuries that you have experienced. Begin with most recent*

Type of injury	Treatment received	Date of injury

❖ *List any athletic injuries that you have experienced below. Begin with the most recent*

Type of injury	Treatment received	Date of injury

❖ *List any other injuries that you have experienced below. Begin with most recent*

Type of injury	Treatment received	Date of injury

Last Name, First Initial:_____

Review of Systems

Mark any of the following conditions/symptoms that currently pertain to you

❖General

☐Consistent fainting	☐Chills	☐Convulsions	☐Depression	☐Dizziness
☐Loss of weight	☐Fatigue	☐Fever	☐Headaches	☐Loss of sleep
☐Weight gain	☐Neuralgia	☐Night sweats	☐Wheezing	☐Nervousness

❖ Gastro-Intestinal

☐Constipation	☐Diarrhea	☐Gall bladder issues	☐Hemorrhoids	☐Poor digestion
☐Liver problems	☐Nausea	☐Stomach pain	☐Poor appetite	☐Changes in urgency
☐Rectal bleeding	☐Vomiting	☐Vomiting blood	☐Jaundice	☐Changes in frequency

❖ Eye/Ear/Nose/Throat

☐Asthma	☐Sore throat	☐Tonsillitis	☐Blurry vision	☐Earache
☐Ear noises (tinnitus)	☐Enlarged thyroid	☐Crossed eyes	☐Double vision	☐Ear discharge
☐Nasal obstruction	☐Nose bleeds	☐Worsening vision	☐Eye pain	☐Deafness
☐Hay fever	☐Sinusitis	☐Hoarseness	☐Changes in sense of smell	☐Changes in sense of taste

❖ Respiratory

☐Chronic cough	☐Chest pain	☐Difficulty taking normal breath	☐Difficulty taking deep breath	☐Wheezing
☐Heaviness in chest	☐Coughing blood	☐Coughing phlegm		

❖Musculoskeletal

☐Backache	☐Foot pain	☐Pain between shoulder-blades	☐Painful tailbone	☐Neck stiffness
☐Spinal curvature	☐Loss of range of motion	☐Weakness	☐Changes in muscle tone	☐Muscle twitching
☐Muscle tremors	☐Swollen joints	☐Changes in gait		

❖Cardio-Vascular

☐Ankle swelling	☐Poor circulation	☐High blood pressure	☐Low blood pressure	☐Heart fluttering/ palpitations
☐Rapid heartbeat	☐Slow heartbeat	☐Pain over heart	☐Venous insufficiency	

❖Skin

☐Dryness	☐Bruise easily	☐Hives	☐Itching	☐Eczema
☐Sensitive skin	☐Skin discolorations	☐Thinning of skin		

❖Neurological

☐Attention problems	☐Mental fogginess	☐Mental fatigue	☐Mood changes	☐Lack of motivation
☐Incoordination	☐Difficulty with word retrieval	☐Difficulty remembering names	☐Difficulty remembering faces	☐Difficulty expressing feelings
☐Difficulty recalling memories	☐Difficulty understanding directions	☐Difficulty with simple math calculations	☐Difficulty with comprehension	☐Difficulty finishing tasks
☐ Abnormal sensations	☐Uncontrollable movements	☐Increased anxiety or panic	☐Increased sensitivity to light	☐Increased sensitivity to touch
☐Increased sensitivity to sound	☐Easily get annoyed/ frustrated			

❖*Please note any additional comments or concerns you would like us to know regarding your health*

❖*I understand and agree to the following:*

❖ *It is my responsibility to complete the clinic's forms accurately and provide the most up to date information*

❖ *It is my responsibility to notify the doctor if any of the information has changed or requires updating*

Signature of patient Date

Signature of Guardian Relationship to patient Date