RECHARGE CHIROPRACTIC
& SPORTS INJURY CENTER

Confidential Health History

Contact Information

Date: _____

Name: _____

Sex: ☐ male ☐ female Age: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer's Name: _____

Work Phone: _____ Best time and place to reach you: _____

E-mail: _____ May we contact you through e-mail? ☐ yes ☐ no

Are you: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

In case of emergency, contact: _____ Relationship: _____

Phone numbers for emergency contact: _____

How did you hear about us? _____

Health History

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor (Explain): _____

Major Accidents or Falls: _____

Hospitalizations – Dates: _____

Surgeries: _____

Broken Bones: _____

Drugs/Medications (Current): _____

Allergies: _____

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

What type of exercise do you engage in? _____

Work Activity: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Smoking/Nicotine use: ☐ Yes, # of packs per day _____ ☐ No

Alcohol use: ☐ Yes, # of drinks per week _____ ☐ No

Coffee/Caffeine: ☐ Yes, # of cups/drinks per day _____ ☐ No

High Stress Level: ☐ Yes, Reason: _____ ☐ No

Females: Pregnant? ☐ Yes ☐ No If Yes: How Long? _____ Nursing Child? ☐ Yes ☐ No

Date of Last Physical Exam: _____ Spinal Exam: _____

MRI/CT Scan/Bone Scan: _____ Spinal X-Ray: _____

Other X-Ray: _____ Type: _____

Lab Work (i.e. blood tests, urine tests): _____

Check 'Yes' or 'No' to indicate if you have or have had any of the following:

HIV/AIDS	☐ Yes ☐ No	Measles	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Mumps	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Fractures	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Goiter	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Gonorrhea	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Gout	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Hernia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Herniated Disk	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Herpes	☐ Yes ☐ No	Other	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	_____	
Kidney Disease	☐ Yes ☐ No	_____	
Liver Disease	☐ Yes ☐ No		

Details of any of the above conditions: _____

_____

_____

Current Health Condition

Primary Complaint: _____

When did it start? _____

Is this condition getting progressively worse? ☐ yes ☐ no ☐ unknown

Rate the severity of your symptoms on a scale of 0 to 10 when 0 = no pain at all and 10 = severe pain.

Please circle: 0 1 2 3 4 5 6 7 8 9 10

How would you describe the pain/symptoms? Check all that apply:

☐ Dull Ache ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Numbness ☐ Tingling

☐ Cramping ☐ Stiffness ☐ Swelling ☐ Shooting/Radiating ☐ Other _____

How often do you have the pain? ☐ Daily ☐ Weekly ☐ Monthly ☐ Sporadically

The pain: ☐ is constant ☐ comes and goes ☐ other _____

Does the pain interfere with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

What aggravates the pain? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lifting

☐ Lying down ☐ Coughing ☐ Sneezing ☐ Other_____

What relieves the pain? ☐ Rest ☐ Exercise ☐ Sitting ☐ Standing ☐ Lying ☐ Other _____

Have you ever had medical treatment for this condition before? ☐ Yes ☐ No

If yes, what treatment have you received? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ Other _____

When did you receive this treatment? _____

Name, phone number and address of other professionals who have treated you for your condition:

_____

Have you ever had the same or a similar problem before? ☐ Yes ☐ No If Yes, When: _____

Explain: _____

Is your current condition due to: ☐ Exercising ☐ Auto Accident* ☐ Work Accident* ☐ Fall ☐ Unknown

*If due to an accident, please complete the accident information portion of this form.

Accident Information

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other _____

Date of Accident: _____ State and County where accident occurred: _____

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker's Comp. ☐ Other_____

Claim or Case Number: _____

Attorney's Name and phone number (if applicable): _____

Patient Statement

I certify that the information that I have given is true and correct to the best of my knowledge.

_____ _____

Patient or Guarantor Signature Date