Shippy Chiropractic – Confidential Personal History

Name _____SS# _____-_____-_____
Address _____City _____State _____Zip _____
Cell Phone (____)_____-_____Home Phone (____)_____-_____Work Phone (____)_____-_____
Sex _____Birth Date _____/_____/_____Age _____Marital Status ❑M ❑S ❑W ❑D
Email _____Name of Spouse/Partner _____
Referred by _____Number of Children _____
Occupation or Profession _____Employed By _____
Previous Chiropractic Care? ❑ Yes ❑ No If Yes, with whom? _____
Name of Family Physician _____
Do you have health Insurance? ❑ Yes ❑ No What Company?_____
Present Complaint (Explain) _____
_____
_____
Cause _____Date of Onset _____Duration _____
Treatment thus far for this complaint _____

Do not write in this space

Physician: _____

History: Injuries, (Auto, Work Related, Etc.) Please Explain _____
_____
_____

Check the Following Illnesses that you have had in past:

❑ Measles	❑ Pneumonia	❑ Gonorrhea	❑ Nervousness
❑ Mumps	❑ Pleurisy	❑ Syphilis	❑ Nervous Breakdown
❑ Chickenpox	❑ Tuberculosis	❑ Gall Stones	❑ "Leaking" Heart (Murmurs)
❑ Smallpox	❑ Migraine	❑ Kidney Stones	❑ Rheumatic Fever (Chorea)
❑ Diphtheria	❑ Arthritis	❑ Kidney Disease	❑ Hepatitis or Jaundice
❑ Whooping Cough	❑ Diabetes	❑ Cancer	❑ Hives or Eczema
❑ Polio	❑ Goiter	❑ Meningitis	❑ Any Bone or Joint Disease
❑ Scarlet Fever	❑ Anemia	❑ Epilepsy	❑ Low Blood Pressure
❑ Hay Fever	❑ Fractures	❑ Heart Disease	❑ High Blood Pressure
	❑ Allergies	❑ Asthma	❑ Other _____

Family History: Put an "X" in front of those which apply:

	Living	*Dead*	*Cancer*	*T.B.*	*Diabetes*	*Blood Disease*	*Allergy*	*Heart*	*Arthritis*	*Other*
Father	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

I believe the front and back of this Confidential History to be true and accurate to the best of my knowledge.

Patient Signature _____ *Date* _____

Surgical History: Put the <u>year</u> in front of those surgeries which you have had:

_____Cholecystectomy (Gall Bladder) _____Hysterectomy (Uterine) _____ Adenoidectomy
_____ Herniorraphy (Hernia) _____ Prostatectomy (Prostate) _____ Appendectomy
_____ Hemorrhoidectomy (Hemorrhoid) _____ Tonsillectomy _____ Vaginal Repair
Other _____

Current Symptoms: Check those that presently apply:

Skin
- ❑ Rashes
- ❑ Eruptions
- ❑ Discolorations

Weight
- ❑ Gain
- ❑ Loss
- ❑ Remain the Same

Throat
- ❑ Soreness
- ❑ Hoarseness
- ❑ Difficulty Swallowing

Stomach or Intestines
- ❑ Poor Appetite
- ❑ Nausea
- ❑ Vomiting
- ❑ Belching
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Rectal Bleeding
- ❑ Irregular Stool
- ❑ Hernia
- ❑ Ulcers

Head
- ❑ Headaches
- ❑ Trauma
- ❑ Dizziness
- ❑ Fainting

Ears
- ❑ Deafness
- ❑ Discharge
- ❑ Ringing
- ❑ Excess Wax

Nose
- ❑ Sinusitis
- ❑ Bleeding
- ❑ Post Nasal Drip
- ❑ Obstruction

Chest
- ❑ Pain
- ❑ Heart Pounding
- ❑ Difficulty Breathing
- ❑ Cough up Blood

Muscular
- ❑ Numbness
- ❑ Joint Pain
- ❑ Varicosities
- ❑ Swelling of hands or feet

Urinary (Urination)
- ❑ Abnormally Frequent
- ❑ Burning
- ❑ Pain
- ❑ Discolored with Blood or Pus

Habits
- ❑ Coffee
- ❑ Tea
- ❑ Milk
- ❑ Water
- ❑ Fruit Juices
- ❑ Alcohol
- ❑ Cigarettes
- ❑ Drugs (Pot, etc.)
- ❑ Diets
- ❑ Other

Eyes
- ❑ Double Vision
- ❑ Glasses
- ❑ Tearing
- ❑ Burning
- ❑ Eye Strain
- ❑ Sensitive to Light

Female Only
- ❑ Periods Irregular
- ❑ Periods Regular
- ❑ Duration of Periods
- _____ Number of Pregnancies
- ❑ Complications during pregnancy
- ❑ Menopause

Put an "X" on each line where it applies.

	Never	Occasionally	Frequently	Daily
Laxatives	❑	❑	❑	❑
Diuretics (Water Pills)	❑	❑	❑	❑
Appetite Suppressants	❑	❑	❑	❑
Vitamins	❑	❑	❑	❑
Antibiotics	❑	❑	❑	❑
Aspirin or Related Compounds	❑	❑	❑	❑
Sleeping Pills	❑	❑	❑	❑
Sedatives (Tranquilizers)	❑	❑	❑	❑
Hypotensive Agents (Blood Pressure)	❑	❑	❑	❑
Digitalis	❑	❑	❑	❑
Nitroglycerine	❑	❑	❑	❑
Cortisone, SCTH or Other Steroids	❑	❑	❑	❑
Orinase, Diabenese	❑	❑	❑	❑
Insulin	❑	❑	❑	❑
Other Hormones	❑	❑	❑	❑

Other Medications (Please List)
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

X Ray Survey:

Have you been X-Rayed before? ❑ Yes ❑ No When? _____How Many Times?_____
Where? _____What Body Region? _____
Have you ever had X-Ray treatments? ❑ Yes ❑ No When? _____ For How Long? _____
Have you ever had Chemotherapy? ❑ Yes ❑ No When? _____ For How Long? _____
FEMALES: Are you currently pregnant? ❑ Yes ❑ No Date of last menses _____