# Mountain Creek Chiropractic History Form

**Name**_____ **Date**_____
**Address**_____ **Date of Birth**_____
**City**_____ **State**_____ **Zip**_____
**Home Phone**_____ **Cell Phone** _____**E-mail**_____
**Occupation** _____ **Employer/School**_____ **Gender: M F**

**Single Married Divorced Widowed Partnered**
**Spouse's Name**_____

**Whom may we thank for referring you to our office?** _____

## MAIN PROBLEM

What symptom causes you to come to the office?_____
What causes this symptom?
_____

How often does the symptom occur? (Circle the one that applies) **Occasional Frequent Constant**
When did the pain start? _____
Has it been getting better, worse, or staying the same? _____

How bad is this symptom? (Circle the one that applies) **Mild Moderate Severe Intolerable**

Circle the word(s) that best describe your symptom. **Sharp Dull Diffuse Achy Burning**

**Shooting Stiff Numb Tingly Sharp w/ Motion Stabbing w/ Motion Electric-like w/ Motion Deep**

Does this symptom **travel to any other area**? _____
What makes this symptom **better**? _____
What makes the symptom **worse**? _____
What else have you done to treat this symptom? _____
Did it help? _____

## OTHER PROBLEM

What other symptoms do you have?_____
What caused the symptom?
_____

How often does the symptom occur? (Circle the one that applies) **Occasional Frequent Constant**
When did the pain start? _____
Has it been getting better, worse or staying the same? _____
How bad is this symptom? (Circle the one that applies) **Mild Moderate Severe Intolerable**

Circle the word(s) that best describe your symptom. **Sharp Dull Diffuse Achy Burning**

**Shooting Stiff Numb Tingly Sharp w/ Motion Stabbing w/ Motion Electric-like w/ Motion Deep**

Does this symptom **travel to any other area**? _____
What makes this symptom **better**? _____
What makes the symptom **worse**? _____
What else have you done to treat this symptom? _____
Did it help? _____

Have you ever been to a chiropractor before? ☐ Yes ☐ No

If so, when & why?

_____

## INJURIES/SURGERIES YOU HAVE HAD:

**Description of incident** **Date of incident**

Falls_____
Head Injuries_____
Broken bones_____
Dislocations_____
Surgeries_____
_____
Car Accidents_____
_____

Please check all symptoms that are a concern to you.

**✕ = currently have** **O = have had at some point in your past** **⊗ = comes and goes** **F = family history**

___ Headaches
___ Neck Pain
___ Upper Back Pain
___ Mid Back Pain
___ Low Back Pain
___ Shoulder Pain
___ Elbow/Upper Arm Pain
___ Wrist Pain
___ Hand Pain
___ Hip Pain
___ Upper Leg Pain
___ Knee Pain
___ Lower Leg Pain
___ Ankle/Foot Pain

___ Jaw Pain
___ Joint Pain/Stiffness
___ Arthritis
___ Rheumatoid Arthritis
___ Cancer
___ Tumor
___ Asthma
___ Chronic Sinusitis
___ Irritable bowel syndrome
___ High Blood Pressure
___ Hearth Attack
___ Chest Pains
___ Stroke
___ Angina

___ Kidney Stones
___ Kidney Disorders
___ Bladder Infection
___ Painful Urination
___ Loss of Bladder Control
___ Prostate Problems
___ Abnormal Weight Gain/Loss
___ Loss of Appetite
___ Abdominal Pain
___ Sterility/Infertility
___ Ulcer
___ Hepatitis
___ Liver/Gall Bladder Disorder
___ Drug/Alcohol Dependence

___Muscular Incoordination
___ Visual Disturbances
___ Dizziness
___ Diabetes
___ Excessive Thirst
___ Frequent Urination
___ Allergies
___ Depression
___ Systemic Lupus
___ Epilepsy
___ Dermatitis/Eczema/Rash
___ HIV/AIDS
___ Smoking/Tobacco Use
___ General Fatigue

**List any other conditions you have**:_____

**Circle if you currently have any of the following**: Osteoporosis, benign bone tumors of the spine, bleeding disorders & anticoagulant therapy, radiculopathy with progressive neurological signs, acute rheumatoid arthritis, ankylosing spondylitis, acute or healed and unstable fracture/dislocation, unstable os odontoideum, spinal column malignancy, spinal column infection of the bones or joints, myelopathy or cauda equina syndrome, vertebrobasilar insufficiency syndrome, major artery aneurysm

**List any medications you have taken in the last 3 months**: (prescription, over-the-counter, vitamins, herbs, cigarettes, alcohol use) _____
_____

*The statements made on this form are accurate to the best of my recollection and I agree to allow Dr. Davy Addison, D.C. to examine me for further evaluation:*

**Patient Signature**: _____ **Date**: _____ **Pt ID#**:_____
**Provider Signature**: _____**Date**: _____
Davy Addison, D.C