SIMSBURY CHIROPRACTIC & WELLNESS CENTER

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Cheryl Vincent, DC, DABCI •

CONFIDENTIAL PATIENT INFORMATION

All patient information is confidential and is released to others only with your approval. Answering all questions completely helps the doctor determine the extent of your health problems and verifies that they have a chiropractic solution. If we do not sincerely believe that we can help you; we will help you find someone who can.

Name ______________________ Birthdate __________ Date ______________

Heard about our office through ______________________________

List your primary reason for your appointment – Chiropractic, Acupuncture, Holistic Primary Care

____

____

List your health care concerns or symptoms:

____

____

Over the past _____ (days – weeks – months – years)

My health problems have been:

- ❑ Rapidly Getting worse
- ❑ Staying About the Same
- ❑ Gradually Getting Worse
- ❑ Getting Better

Comments ______________________________

____

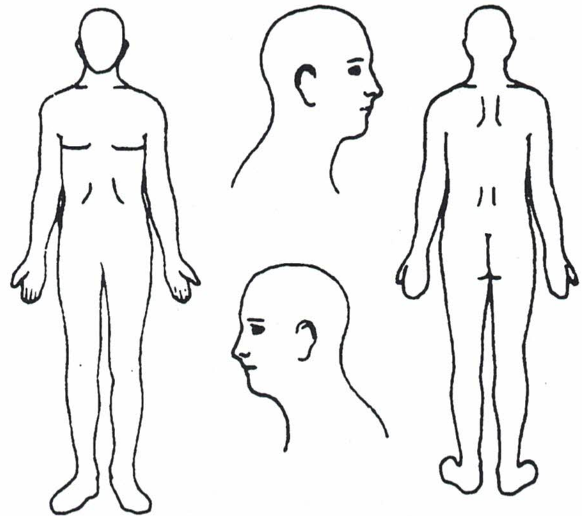
I would describe my pain as (circle as many as apply):

Constant	Frequent	Intermittent	Occasional
Very Severe	Severe	Moderate	Mild
Stabbing	Sharp	Dull	Aching

Other ______________________________

____

Please mark your areas of pain on the figures below.



Have you ever had chiropractic care before? Y N

List other doctors consulted for these health problems:

Name ______________________ When Consulted: ______________________

Diagnosis ______________________ Treatment ______________________

How long did you see the Doctor" ______________ How frequently? ______________

Results ______________________________

Name ______________________ When Consulted: ______________________

Diagnosis ______________________ Treatment ______________________

How long did you see the Doctor" ______________ How frequently? ______________

Results ______________________________

Present Family Doctor? ______________________________

Date of last physical examination? ______________ By Doctor? ______________

Date of last blood work? ______________ Have you had any recent x-rays, MRI's or other diagnostic test? __________

What surgeries have you had?

Type / When / Doctor / Remarks ______________________________

____

____

List all previous serious accidents, serious falls, all broken bones (auto, work, home, leisure, sports, other - circle one)

What / When / Symptoms / Treatment / Results ______________________________

____

____

List all medications and/or diet supplements you take and the reason needed

What / Frequency / Doctors / Side Effects / Remarks ____________________

____

____

Environment

Work - (Please circle appropriate answer)

Seated / Standing – Work Bench / Desk / Counter / Other ____________________

Job requires – Physical exertion / Lifting / Bending / Stooping / Twisting / Turning / Carrying / Walking / Standing / Other ____________

Chair – Executive / Steno / Bench / Stool / Folding / Other ____________ Shoes – High Heels / Boots / Other ____________

Leisure

Sedentary Activities - Standing / Seated / Lying – TV / Reading / Card Games / Sewing / Other (Please describe)

____

Strenuous Activities – Exercise - Type / Frequency / Length of Time

____

Sports – Type / Frequency / Length of Time (if you have discontinued sports or strenuous activities, why the change?)

____

Do you physically exert yourself – Frequently / Occasionally / Rarely / Never - Describe how

____

What else should the doctor know about your health?

____

____

____

Sleep ____________ hrs/night Do you sleep on your ❑ Back ❑ Side ❑ Stomach Non-job Exercise ____________ hrs/week

Age of Mattress ____________ or waterbed ____________ Is your bed comfortable? ❑ No ❑ Yes

What kind of pillow do you use? ❑ Thick ❑ Medium ❑ Thin ❑ None ❑ Support

Do you wear ❑ Heel Lifts ❑ Shoe Lifts ❑ Arch Supports ❑ Orthotics, describe ____________________

CONDITIONS

Check (✓) conditions you have or have had in the past

❑ AIDS	❑ Diabetes	❑ Liver Disease	❑ Rheumatic Fever
❑ Alcoholism	❑ Emphysema	❑ Measles	❑ Scarlet Fever
❑ Anemia	❑ Epilepsy	❑ Migraine Headaches	❑ Stroke
❑ Anorexia	❑ Fractures	❑ Miscarriage	❑ Suicide Attempt
❑ Appendicitis	❑ Glaucoma	❑ Mononucleosis	❑ Thyroid Problems
❑ Arthritis	❑ Goiter	❑ Multiple Sclerosis	❑ Tonsillitis
❑ Asthma	❑ Gonorrhea	❑ Mumps	❑ Tuberculosis
❑ Bleeding Disorders	❑ Gout	❑ Osteoporosis	❑ Tumors / Growths
❑ Breast Lump	❑ Heart Disease	❑ Pacemaker	❑ Typhoid Fever
❑ Bronchitis	❑ Hepatitis	❑ Pneumonia	❑ Ulcers
❑ Bulimia	❑ Hernia	❑ Polio	❑ Vaginal Infections
❑ Cancer	❑ Herpes	❑ Prostate Problem	❑ Venereal Disease
❑ Cataracts	❑ High Cholesterol	❑ Prosthesis	❑ Whooping Cough
❑ Chemical Dependency	❑ HIV Positive	❑ Psychiatric Care	❑ Other ____________
❑ Chicken Pox	❑ Kidney Disease	❑ Rheumatoid Arthritis	____________

GENERAL SYMPTOMS

Check (✓) symptoms you currently have or have had in the past year

GENERAL	❑ Fainting	❑ Nervousness	❑ Frequent Urination
❑ Bruise Easily	❑ Fever	❑ Numbness	❑ Lack of Bladder Control
❑ Chills	❑ Forgetfulness	❑ Sweats	❑ Painful Urination
❑ Dental Problems	❑ Headaches	❑ Tiredness	**GASTROINTESTINAL**
❑ Depression	❑ Loss of Sleep	❑ Weight Gain	❑ Appetite Poor
❑ Difficulty Sleeping	❑ Loss of Weight	**GENITO-URINARY**	❑ Bloating
❑ Dizziness		❑ Blood in Urine	❑ Bowel Changes

- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earaches
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN

- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sore That Won't Heal

MEN only

- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Other ____________________

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding Between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Other ____________________

Date of Last Menstrual Period? ____________________

Date of Last Pap Smear? ____________________

Have you had a Mammogram? ____________________

Are you Pregnant? ____________________

Number of Children? ____________________

NECK, BACK & EXTREMITIES

Check (✓) symptoms you currently have or have had in the past year

NECK

- ☐ Pain
- ☐ Stiffness
- ☐ Weakness
- ☐ Pinched Nerve
- ☐ Feels out of Place
- ☐ Muscle Spasms
- ☐ Grinding Sounds
- ☐ Popping Sounds

SHOULDERS

	RIGHT	LEFT
☐ Pain in Shoulder Joint	☐ R	☐ L
☐ Pain Across Shoulders		
☐ Can't Raise Arm	☐ R	☐ L
☐ Above Shoulder Level		
☐ Over Head		
☐ Tension		
☐ Pinched Nerve	☐ R	☐ L

MID-BACK

- ☐ Pain
- ☐ Stiffness
- ☐ Pain between Should Blades
- ☐ Pain from Front to Back
- ☐ Muscle Spasms

ARMS & HANDS

	RIGHT	LEFT
☐ Pain in Upper Arm	☐ R	☐ L
☐ Pain in Elbow	☐ R	☐ L
☐ Pain in Forearm	☐ R	☐ L
☐ Pain in Hand	☐ R	☐ L
☐ Pain in Fingers	☐ R	☐ L
☐ Pins & Needles in Arm	☐ R	☐ L
☐ Pins & Needles in Fingers	☐ R	☐ L
☐ Numbness in Arm	☐ R	☐ L
☐ Numbness in Fingers	☐ R	☐ L
☐ Weakness of Arm	☐ R	☐ L
☐ Weakness of Hand	☐ R	☐ L
☐ Cold Hands	☐ R	☐ L

LOW BACK

- ☐ Pain
- ☐ Stiffness
- ☐ Weakness
- ☐ Pinched Nerve
- ☐ Feels Out of Place
- ☐ Muscle Spasms

HIPS, LEGS & FEET

	RIGHT	LEFT
☐ Pain in Buttocks	☐ R	☐ L
☐ Pain in Hip Joint	☐ R	☐ L
☐ Pain Down Leg	☐ R	☐ L
☐ Pain in Knee	☐ R	☐ L
☐ Pain in Ankle	☐ R	☐ L
☐ Pain in Foot	☐ R	☐ L
☐ Weakness of Leg	☐ R	☐ L
☐ Weakness of Knee	☐ R	☐ L
☐ Leg Cramps	☐ R	☐ L

OTHER SYMPTOMS

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____
____
____
____
____
____
____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____________________ Patient Signature

____________________ Date