

# Basin View Chiropractic

## Confidential Health History

Please check here the type of care desired:     Temporary Relief     Correction and Wellness Care

Name \_\_\_\_\_ D.O.B. (M/D/Y) \_\_\_/\_\_\_/\_\_\_    Age \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ Business Phone \_\_\_\_\_  
Postal Code \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse or Partner's Name \_\_\_\_\_ # of Children \_\_\_\_\_

Were you referred to our office?  Yes  No    If yes, whom may we thank?

\_\_\_\_\_

**I have no specific complaint but wish to have a chiropractic examination for spinal subluxation and overall nervous system function.**

**I have a specific health concern (please describe your major complaint):**

\_\_\_\_\_

How did this condition develop? (What caused it? How did it start?) \_\_\_\_\_

\_\_\_\_\_

When did this begin? \_\_\_\_\_

Have you had this or a similar problem before?  Yes  No    If yes, please explain.

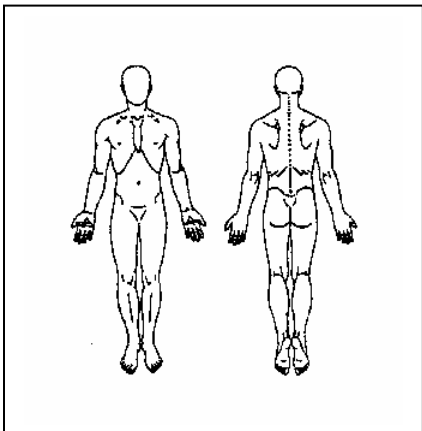
\_\_\_\_\_

Who else have you seen for this condition? \_\_\_\_\_

This problem is     getting better     getting worse     remaining the same.

Is there anything that aggravates your condition? \_\_\_\_\_

Is there anything that relieves your condition? \_\_\_\_\_



If you are in pain, please  
mark the exact location of the  
pain on this diagram.

How has this condition affected your life?

- A. At Home: \_\_\_\_\_
- B. Occupation: \_\_\_\_\_
- C. Recreational: \_\_\_\_\_
- D. Rest and Sleep: \_\_\_\_\_

Have you ever been involved in an accident?  Yes  No If yes, when and what injuries were sustained?

Have you ever had any surgery? If yes, please list the procedure and the date(s):

Please list all drugs/medications you take:

Do you take Non-Steroidal Anti- Inflammatory Drugs (Aspirin, Advil, Motrin, Ibuprofen)? If yes, how often?  
 Daily  3 to 5 times a week  Weekly  2 to 3 times a month  Once a Month  Other \_\_\_\_\_

Have you had any serious illnesses or any of your family members (i.e.: diabetes, cancer, heart disease) If yes, please list who and the nature of the disorder. \_\_\_\_\_

PRESENT HEALTH: Have you within the last 12 months experienced any of the following?

0- OCCASIONAL    F-FREQUENT    C-CONSTANT

	OFC		OFC		OFC
Stiff Neck	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Heartburn	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Migraines	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Back Pain/Ache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Exzema	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Headaches	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Neck Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Digestion problems	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Dizziness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Allergies/Sinus	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Constipation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Numbness or pain in arms, hands, legs or feet	
Earache/Ear Infections	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Shoulder or knee			
Sore Throat	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pain/decreased range of motion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Additional remarks or comments: \_\_\_\_\_

Have you ever seen a Doctor of Chiropractic prior to today?  Yes  No

Should you require any help -with your form please ask the receptionist