Date:_____

Patient History Sheet

Version 10 – 12.7.20

PLEASE PRINT

Patient Name:_____ Date of Birth:_____

Main Reason for today's visit:_____

Other health concerns: _____

Place a check mark in either a Yes or No box for each condition - no lines:

Mark YES or NO and give date of last incident	No	Yes, Now	Yes, Past	Date
Neck pain				
Mid back pain				
Low back pain				
Pain/numb shoulder / elbow				
Pain/numb wrist or arm				
Pain/numb hip or leg				
Pain/numb knee or ankle				
Night Sweats				
Weight Change				
Fatigue				
Blurred Vision				
Eye Problems				
Deafness				
Vertigo/Dizziness				
Ear Aches				
Nosebleeds				
Dry Mouth				
Nasal Congestion				
Dental pain/infection/cavity				
Heartburn / Reflux				
Breast / Chest Pain				
Breast abnormalities				
Allergies				
Asthma				
COPD				
Respiratory Problems				
Cold Extremities				
High Blood Pressure				
High Cholesterol				
Shortness of Breath				

Mark YES or NO and give date of last incident	No	Yes, Now	Yes, Past	Date
Heart Problems				
Constipation				
Hemorrhoids				
Stomach / Intestine Problem				
Bed Wetting				
Urinary Delay Problems				
Dry Skin				
Lumps				
Skin Problems				
Depression				
Anxiety				
Headaches				
Migraines				
Head Trauma				
Seizures				
Balance/Coordination Issues				
Bipolar				
Memory Problems				
Thyroid Problems				
Painful Menstruation				
Hormonal Imbalances				
Sterility				
Clotting Problems				
Hepatitis				
Excessive Thirst/Hunger				
Diabetes				
Anemia				
HIV				
Gait / Walking / Running				
Other				

Previous Chiropractic Care:

Have you been to a chiropractor before? □ Yes □ No Doctor's name and date of last visit:_____

Surgeries, Hospitalizations (including childbirth) or Accidents:

Have you had any surgeries, hospitalizations, or accidents? □ Yes □ No If yes, explain below:

1. _____ Year:_____
2. _____ Year:_____
3. _____ Year:_____
4. _____ Year:_____
5. _____ Year:_____
6. _____ Year:_____

Please Continue to Page 2

eriksen chiropractic centers

Date:_____

Patient Name: _____

Patient History Sheet, Page 2

Family History

Relationship	Heart disease	Stroke	Diabetes	Cancer	Other – Explain:	Age	If no longer living, cause of death and age at time of death
Father							
Mother							
Brother/Sister							
Child							
Mother's family							
Father's family							

Social History

1. Do you smoke or use other tobacco products? □ Yes □ No If yes, packs per day: _____
2. Have you smoked or used tobacco in the past? □ Yes □ No Total years used: _____
   Average packs per day: _____ Year quit: _____
3. Do you drink alcohol? □ Yes □ No
   Servings per week: 12-ounces beer: _____ 5-ounces wine: _____ Ounces of liquor: _____
4. Do you drink coffee or other caffeine products? □ Yes □ No If yes, cups/drinks per day: _____
5. Family history of substance abuse? □ Yes □ No
6. Personal history of substance abuse? □ Yes □ No
7. Do you exercise? □ Yes □ No Times per week: _____ Minutes per session: _____
   Types of exercise:_____
8. Hobbies / social activities:_____
9. Are you retired? □ Yes □ No
10. Are you disabled in some way? □ Yes □ No If yes, type / extent of disability:_____
11. Do you have any allergies (environmental, drug, latex, etc.)? □ Yes □ No

    If yes, please list: _____

Current Medication History

Medication	Dose	Frequency	Reason for taking	Date First Prescribed
1.				
2.				
3.				
4.				
5.				
6.				

Do you have a primary care physician? □ Yes □ No Physician's name: _____

If yes, may we provide your PCP with a copy of records from your treatment with us and keep them informed as to your progress? □ Yes □ No

When was the last time you saw a health care provider? _____

Do you have an advance will or living directive? □ Yes □ No

If yes, please bring a copy in for our records