



PEARSON

Chiropractic & Rehabilitation Center

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HISTORY CHECKLIST

Patient Name _____ No. _____

Date of Birth _____ Claim No. _____

Doctor _____ Date _____

- Do you have chest pain? Yes No
- Do you have any change in bowel or bladder habits? Yes No
- Do you have a sore that does not heal? Yes No
- Do you have any unusual bleeding or discharge? Yes No
- Do you have any thickening in your breasts or elsewhere? Yes No
- Do you have indigestion or difficulty in swallowing? Yes No
- Do you have any change in a wart or a mole? Yes No
- Do you have a nagging cough or hoarseness? Yes No
- Do you have headaches for hours or days? Yes No
- Do you have blurred vision? Yes No
- Do you have night sweats? Yes No
- Do you have pain in your neck, jaw or face? Yes No
- Do you have a drooping eyelid or and change in your pupils? Yes No
- Do you have vertigo (dizziness)? Yes No
- Do you have double vision? Yes No
- Do you have any visual disturbances? Yes No
- Do you have any nausea or vomiting? Yes No
- Do you have any slurred speech? Yes No
- Do you have any ringing in your ears? Yes No
- Do you pass out easily (faint)? Yes No

- Do you take birth control pills? Yes No
- Do you have a history of stroke in your family? Yes No
- What prescription medications are you taking if any?
 - High blood pressure medication
 - Blood thinners
 - Other _____
 - List allergies or adverse reactions to medications

- Have you ever had cancer? Yes No
- Does your pain ever wake you from a sound sleep? Yes No
- Are you losing weight now without trying? Yes No
- Are you coughing up blood or noticing it in your stools or urine? Yes No
- Have you had any loss of bladder or bowel control? Yes No
- Have you lost consciousness or had double vision recently? Yes No
- Are you seeing any other doctor for any other reason? Yes No

Note: _____

Are you taking any medications or over the counter drugs? Yes No

Type: _____

What was the date of the onset of your last menses? _____

Social History

Smoker? Yes No

If yes, how many packs? _____

Alcohol? Yes No

If yes, how much? _____

Family History

Did your mother or father have any of the following: Put an **M** for mother, **F** for father, and **B** for both.

- | | | | |
|----------------------------|----------------------|---------------------------------|----------------------------|
| _____ High Blood Pressure | _____ Asthma | _____ Ulcer or Stomach Problems | _____ Thyroid Disease |
| _____ Heart Attack | _____ Diabetes | _____ Stroke | _____ Circulation Problems |
| _____ Emphysema | _____ Kidney Disease | _____ Arthritis-Rheumatism | _____ Cancer |
| _____ Seizures/Convulsions | _____ Pacemaker | _____ Mental Illness | _____ Osteoporosis |
| _____ HIV Positive | | | |

Comments

Show Area(s) of Pain or Unusual Feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.

Mark all areas of radiation. Include all affected areas.

Numbness

Pins & Needles

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 00000000
 00000000
 00000000

Burning

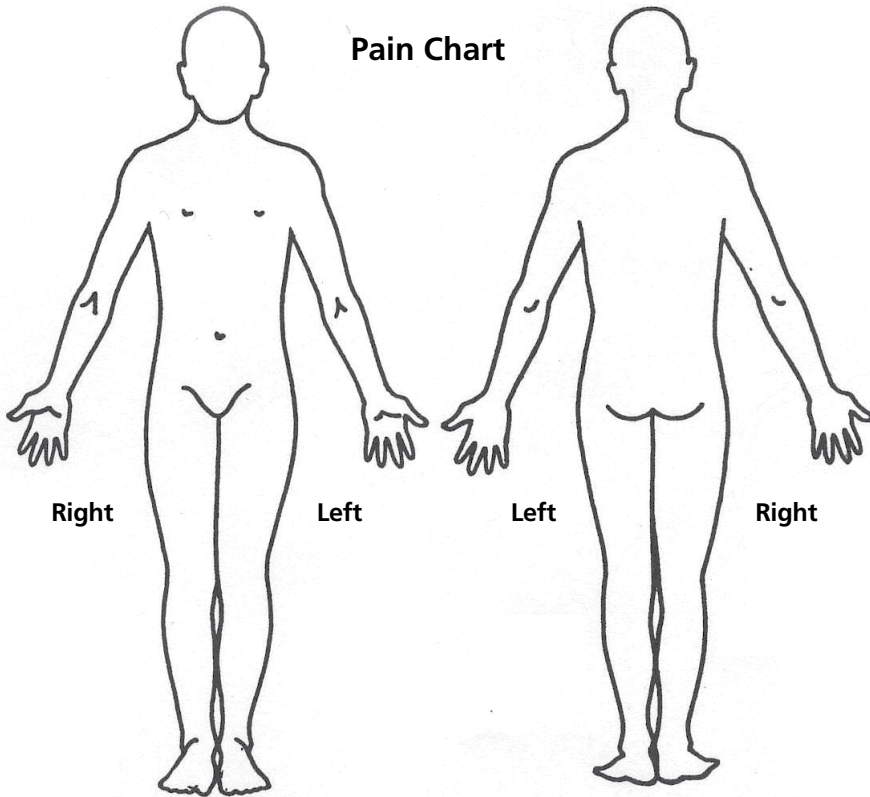
XXXXXXXXXX
 XXXXXXXXXX
 XXXXXXXXXX
 XXXXXXXXXX

Aching

Stabbing

/ / / / /
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Pain Chart



Please mark on the pain scale from 0 to 10 the pain you feel with this condition, 10 being the worst pain you have felt with this condition.

Pain Scale

Neck-Shoulder-Arm Pain

On a scale of 0 to 10.
 I rate my discomfort as follows

0 no pain 10 severe pain

Mid-Back Pain

On a scale of 0 to 10.
 I rate my discomfort as follows

0 no pain 10 severe pain

Lower Back Pain

On a scale of 0 to 10.
 I rate my discomfort as follows

0 no pain 10 severe pain

Date _____

Signature _____