PEARSON
Chiropractic & Rehabilitation
www.pearsonchiropractic.com

HISTORY CHECKLIST

Patient Name _____ No. _____

Doctor _____ Date _____

Date of Birth _____ Claim No. _____

System Review (Have you had any problems with or treatment of any of the following? If yes, please describe.)

ALL PATIENTS		
Do you get dizzy when you turn your head and look back?	☐ Yes ☐ No	
Thyroid	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Head/Brain	☐ Yes ☐ No	
Eyes/Ears/Nose/Throat	☐ Yes ☐ No	
Lungs	☐ Yes ☐ No	
Heart/Blood Pressure	☐ Yes ☐ No	
Stomach/Bowel	☐ Yes ☐ No	
Bladder/Kidney	☐ Yes ☐ No	
Prostate	☐ Yes ☐ No	
Skin	☐ Yes ☐ No	
Nerves	☐ Yes ☐ No	
Medications	☐ Yes ☐ No	
Psychiatric	☐ Yes ☐ No	
Blood/Lymph/Immune System	☐ Yes ☐ No	

FEMALE PATIENTS ONLY		
Are your pregnant?	☐ Yes ☐ No	Date of last menses:
Are you taking birth control pills or shots?	☐ Yes ☐ No	
Thickening of the breast or breast pain?	☐ Yes ☐ No	
Vaginal bleeding or discharge?	☐ Yes ☐ No	

Past Medical History (Have you had any of any of the following? If yes, please describe.)

Cancer	☐ Yes ☐ No	
On the job injuries	☐ Yes ☐ No	When? Which body part?
Motor vehicle accident	☐ Yes ☐ No	When?
Other injuries	☐ Yes ☐ No	
Illnesses	☐ Yes ☐ No	
Hospitalizations	☐ Yes ☐ No	
Surgeries	☐ Yes ☐ No	
Allergies	☐ Yes ☐ No	
Implants or Joint Replacements	☐ Breast ☐ Knee ☐ Hip ☐ Other (specify)	

Family History (Did your mother or father have any of the following? Put an **M** for mother, **F** for father, **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			

Social History

What level of education have you completed? ☐ Elementary ☐ Jr. High ☐ High School ☐ College (2 year) ☐ College (4 year)

Have you served in the military? ☐ Yes ☐ No Where?_____

What is your occupation?_____ Are you retired? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No How much per week?_____

Do you use alcohol? ☐ Yes ☐ No How much per week?_____

What are your hobbies?_____

Other Medical Information

Do you have chest pain? ☐ Yes ☐ No

Do you have a sore on your skin that does not heal? ☐ Yes ☐ No

Do you have a nagging cough or hoarseness? ☐ Yes ☐ No

Do you have night sweats? ☐ Yes ☐ No

Do you have pain in or numbness your jaw or face? ☐ Yes ☐ No

Do you have a drooping eyelid or and change in your pupils? ☐ Yes ☐ No

Do you have any nausea or vomiting? ☐ Yes ☐ No

Do you have any slurred speech? ☐ Yes ☐ No

Have you noticed changes in your balance? ☐ Yes ☐ No

Have you noticed changes in your memory? ☐ Yes ☐ No

Do you have any ringing in your ears? ☐ 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 lost consciousness recently? ☐ Yes ☐ No

Are you seeing any other doctor for any other reason? ☐ Yes ☐ No

Note:_____

Comments

I certify that the information I give is correct to the best of my knowledge. I will not hold the doctors or staff responsible for any errors or omissions that I may have made and I authorize this office to provide chiropractic care.

Print Patient Name_____ Date_____

Patient Signature_____

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SUBJECTIVE REPORT

Date _____

Name _____

WHEN did the pain start? _____

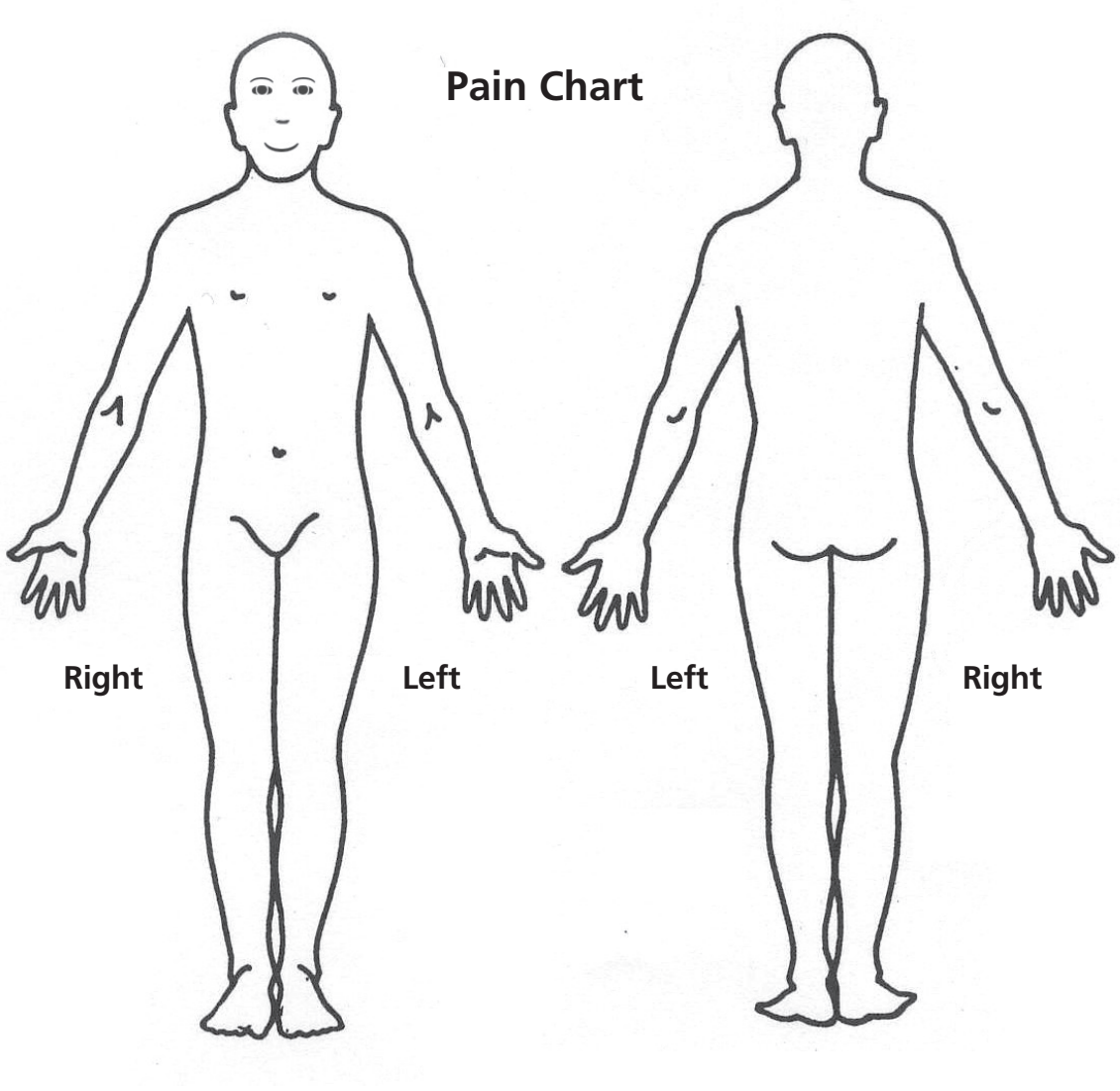
HOW did the pain start? _____

_____

_____

_____

On the body diagrams below, please circle all areas in which you have pain.
Then place a number for your level of pain inside the circle. **1** is good and **10** is your worst pain ever.



_____ _____

Date Signature

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