**New Patient Medical History Form**

Conover Chiropractic

Name: Date:

Date of Birth: Age:

**Have you been to a Chiropractor before?** Yes/No

* 1. **If yes, what for?**

**ALLERGIES** o **NO ALLERGIES**

|  |  |
| --- | --- |
| **ALLERGY**  | **ALLERGIC REACTION**  |
|  |  |
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**PAST MEDICAL HISTORY**

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| --- | --- | --- |
| **Do you now or have you ever had:** |  |  |
|  |  |  |
| ❑ Diabetes | ❑ Heart murmur | ❑ Crohn’s disease |
| ❑ High blood pressure | ❑ Pneumonia | ❑ Colitis |
| ❑ High cholesterol | ❑ Pulmonary embolism | ❑ Anemia |
| ❑ Hypothyroidism | ❑ Asthma | ❑ Jaundice |
| ❑ Goiter | ❑ Emphysema | ❑ Hepatitis |
| ❑ Cancer (type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Stroke | ❑ Stomach or peptic ulcer |
| ❑ Leukemia | ❑ Epilepsy (seizures) | ❑ Rheumatic fever |
| ❑ Psoriasis | ❑ Cataracts | ❑ Tuberculosis |
| ❑ Angina | ❑ Kidney disease | ❑ HIV/AIDS |
| ❑ Heart problems | ❑ Kidney stones |  |
|  |  |
| Other medical conditions (please list): |  |
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**WOMEN’S HEALTH HISTORY**

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| --- | --- |
| **Date of Last Menstrual Cycle:**  | **Age of First Menstruation: \_\_\_\_\_ Age of Menopause: \_\_\_\_\_**  |
| **Total Number of Pregnancies:**  | **Number of Live Births:**  |
| **Pregnancy Complications:**  |

**SURGERIES**

|  |  |
| --- | --- |
| **TYPE** *(specify left/right)*  | **DATE**  |
|  |  |
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| **Systems Review** |
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| **In the past month, have you had any of the following problems?** |
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| **General** | **NERVOUS SYSTEM** | **PSYCHIATRIC**  |
| ❑ Recent weight gain; how much\_\_\_\_ | ❑ Headaches | ❑ Depression |
| ❑ Recent weight loss: how much\_\_\_\_ | ❑ Dizziness | ❑ Excessive worries |
| ❑ Fatigue | ❑ Fainting or loss of consciousness | ❑ Difficulty falling asleep |
| ❑ Weakness | ❑ Numbness or tingling  | ❑ Difficulty staying asleep |
| ❑ Fever | ❑ Memory loss | ❑ Difficulties with sexual arousal |
| ❑ Night sweats |  | ❑ Poor appetite |
|  |  | ❑ Food cravings |
| **Muscle/Joints/Bones** | **STOMACH AND INTESTINES** | ❑ Frequent crying |
| ❑ Numbness | ❑ Nausea | ❑ Sensitivity |
| ❑ Joint pain | ❑ Heartburn | ❑ Thoughts of suicide / attempts |
| ❑ Muscle weakness | ❑ Stomach pain | ❑ Stress |
| ❑ Joint swelling | ❑ Vomiting | ❑ Irritability |
| Where? | ❑ Yellow jaundice | ❑ Poor concentration |
|  | ❑ Increasing constipation | ❑ Racing thoughts |
| **EARS** | ❑ Persistent diarrhea | ❑ Hallucinations |
| ❑ Ringing in ears | ❑ Blood in stools | ❑ Rapid speech |
| ❑ Loss of hearing | ❑ Black stools | ❑ Guilty thoughts |
|  |  | ❑ Paranoia |
| **EYES** | **SKIN** | ❑ Mood swings |
| ❑ Pain | ❑ Redness | ❑ Anxiety |
| ❑ Redness | ❑ Rash | ❑ Risky behavior |
| ❑ Loss of vision | ❑ Nodules/bumps |  |
| ❑ Double or blurred vision | ❑ Hair loss |  |
| ❑ Dryness | ❑ Color changes of hands or feet | **OTHER PROBLEMS:** |
|  |  |  |
| **THROAT** | **BLOOD** |  |
| ❑ Frequent sore throats | ❑ Anemia |  |
| ❑ Hoarseness | ❑ Clots |  |
| ❑ Difficulty in swallowing |  |  |
| ❑ Pain in jaw | **KIDNEY/URINE/BLADDER** |  |
|  | ❑ Frequent or painful urination |  |
| **HEART AND LUNGS** | ❑ Blood in urine |  |
| ❑ Chest pain |  |  |
| ❑ Palpitations | **Women Only:** |  |
| ❑ Shortness of breath | ❑ Abnormal Pap smear |  |
| ❑ Fainting | ❑ Irregular periods |  |
| ❑ Swollen legs or feet | ❑ Bleeding between periods |  |
| ❑ Cough | ❑ PMS |  |
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**MEDICATIONS**

Please list any medications you are currently taking:

**FAMILY MEDICAL HISTORY** o **NO SIGNIFICANT FAMILY HISTORY IS KNOWN**

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| --- |
| **FAMILY HISTORY** |
| **If living** | **If deceased** |
|  | Age (s) | Health | Age(s) at death | Cause |
| Father |  |  |  |  |
| Mother |  |  |  |  |
| Siblings |  |  |  |  |
| Grandparents |  |  |  |  |

**SOCIAL HISTORY**

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| --- | --- |
| **Occupation *(or prior occupation)*:**  | Retired/Unemployed/LOA/Disabled  |
| **Employer:**  | **Years of Education or Highest Degree:**  |
| **If employed, do you work the night shift?** Yes/No or N/A  |
| **Marital Status *(check one)*:** o Single o Partner o Married o Divorced o Widowed o Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Do you have children?** Yes/No If yes, how many?  |

**OTHER HEALTH ISSUES**

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| --- | --- |
| **TOBACCO USE** | Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*  |
| ***Current:*** Packs/day \_\_\_\_\_ # of Years \_\_\_\_\_ ***Past:*** Quit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Packs/day \_\_\_\_\_ # of Years \_\_\_\_\_  |
| **Other Tobacco *(check one)*:** o Pipe o Cigar o Snuff o Chew  |
| **ALCOHOL/DRUG USE**  | Do you drink alcohol? Yes/No | * Beer
* Wine
* Liquor
* # Of Drinks/week:
 |
| **Do you use marijuana or recreational drugs?** Yes/No |  |

**OTHER HEALTH ISSUES continued...**

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| --- | --- |
| **SEXUAL ACTIVITY**  | Sexually involved currently? Yes/ No |
| **EXERCISE**  | Do you exercise regularly? Yes/No *(If you answered no, please move to Sleep)*  |
| **What kind of exercise?** ***Duration:*** How long (min.): \_\_\_\_\_\_\_ **How often:** \_\_\_\_\_\_\_\_  |
| **SLEEP**  | How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?  |
| **DIET**  | How would you rate your diet? Good/Fair/Poor  |