Spinal Wellness Chiropractic

2010 N. Plano Rd suite 101, Richardson, TX 75082

Patient Health Survey

Case History

1. What is your main complaint today?
   _____
   _____
2. What is your pain level right now from 0 to 10? _____
3. On the scale below, please circle the severity of your main complaint at its worst:
   None Slight Mild Moderate Severe
   1--------2--------3--------4---------5--------6--------7--------8---------9---------10
4. On the scale below, please circle the percentage of time you experience your main complaint:
   Occasional Intermittent Frequent Constant
   0------10-------20------30------40------50------60------70------80-----90------100
5. When did this condition begin?_____
6. What caused this condition? _____
7. Have you had this condition before? **Y N** If yes, when was the last time? _____
8. How often do you experience recurrences of this condition? _____
9. What makes it feel better? _____
10. What makes it feel worse? _____
11. Please list the dates you were unable to work: _____
12. Have you seen another doctor for this condition? **Y N** If yes, who and when?
    _____
13. Have you seen a doctor in the past 2 years? **Y N** If yes, who and when?_
    _____
14. Have you had a significant weight change in the past year? **Y N** **G**ain or **L**ose? How much?
    _____lbs
15. Have you sustained serious bodily injury as a result of an accident? **Y N** If yes, what were the injuries and approximately when and how were they sustained?
    _____
    _____

16. Have you had any broken bones? **Y N** If yes, which bones? _____ How did it happen? _____ Approximately when did it happen? _____
_____

17. Have you had any surgeries? **Y N** If yes, for what and approximately when?
_____

18. Have you had cancer? **Y N** if yes, what kind? Approximately when were you diagnosed and what is your present status? _____
19. Have you ever had any spinal taps or spinal injections? **Y N**
20. Were you ever knocked unconscious? **Y N**
21. Have you ever had a lapse of memory? **Y N**

22. Are you taking any medications? **Y N** if yes, name the conditions being treated and the medications being used to treat each condition.
_____
_____

23. Are you currently taking any over-counter- medication/ herbal medicines/supplements?
Y N If yes, please indicate: _____
_____
_____

24. Do you have any allergies that you know of? **Y N** If yes, please indicate: _____
_____

25. Do you suffer from any condition other than that for which you are now consulting us?**Y N**If yes, please indicate: _____

System Review

Please indicate if you are experiencing a problem with any of the following body systems.

1. **Eyes, Ears, Nose or Throat** problems? **Y N** If yes, what is the problem?
_____

2. **Musculo- skeletal** (muscle, bone or joint) problems? **Y N** If yes, what is the problem?
_____

3. **Nervous system** (brain, spinal cord or nerve) problems?**Y N** If yes, what is the problem?
_____

4. **Cardio- vascular-respiratory** (heart, blood, blood vessel or lung) problems? **Y N** If yes, what is the problem? _____
_____

5. **Gastro-intestinal** (stomach, pancreas, liver, gall bladder, small intestines or colon) problem? **Y N** If yes, what is the problem? _____
_____

6. **Genito- urinary-reproductive** (kidney, urinary bladder, uterus, ovaries, prostate, testicle, or external genitalia) problems? **Y N** If yes, what is the problem? _____

7. **Endocrine** (hypothalamus, pituitary, pineal, thyroid, thymus, parathyroid, pancreas, adrenal, ovary or testicle) problems? **Y N** If yes, what is the problem? _____

8. **Immune** (tonsils, lymph nodes, thymus, spleen, bone marrow, white blood cells) problems? **Y N** If yes, what is the problem?_____

9. **For female patient**:
    a. Hysterectomy? **Y N** when? _____
    b. Are you pregnant? **Y N** Expected delivery date_____
10. **For male patient:**
    a. Vasectomy? **Y N** when?_____

Social History

1. Exercise? **Y N**If yes, how often and how long? _____what type?_____
2. Tobacco? **Y N** If yes, how many packs/day? _____Hx of smoking _____
3. Alcohol? **Y N** If yes, how many drinks/ day? _____
4. Coffee? **Y N**If yes, how many cups/day?_____
5. Drugs? **Y N** If yes, what are you using and how much/often? _____

Family History

Please indicate if your family members (such as brothers, sisters, parents, maternal/ paternal grandparents, etc…) have experienced the following conditions.

1. Heart disease? **Y N** If yes, who?_____
2. High blood pressure? **Y N** If yes, who?_____
3. Stroke? **Y N** If yes, who?_____
4. Lung disease? **Y N** If yes, who?_____
5. Neurological disease? **Y N** If yes,who?_____
6. Gastro-intestinal disease? **Y N** If yes,who?_____
7. Genito-urinary disease? **Y N** If yes,who?_____
8. Cancer? **Y N** If yes,who?_____
9. Arthritis disease? **Y N** If yes,who?_____

I hereby authorize the Doctor to treat my condition, as he or she deems appropriate. I understand and agree that the amount paid for x-ray is for their examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at anytime while I am a patient of this office. I also agree that I am responsible for all bills they incurred by me at this office.

Patient's Signature: _____ **Date**: _____

Consent to treat a minor: _____ Date: _____

Guardian/Spouse's Signature of Authorizing Care: _____Date: _____