



CONFIDENTIAL PATIENT HISTORY

CLYNE CHIROPRACTIC
& WELLNESS

NAME _____ S.S.# _____ DATE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

H-PHONE _____ W. PHONE _____ CELL PHONE _____ EMAIL _____

DATE OF BIRTH _____ HOW DID YOU HEAR ABOUT US? _____ MARITAL STATUS ___ S ___ M ___ D ___ W

OCCUPATION _____ EMPLOYER _____ # OF CHILDREN _____ AGES _____

PREVIOUS CHIROPRACTIC CARE? ___ YES ___ NO WHAT HAVE YOU HEARD ABOUT CHIROPRACTIC? _____

MAJOR COMPLAINTS

HAVE YOU HAD THIS LONGER THAN A WEEK OR TWO? ___ YES ___ NO IF YES, HOW LONG? _____

HAVE YOU HAD THIS PROBLEM 2 OR MORE TIMES? ___ YES ___ NO IF YES, HOW OFTEN? _____

WHAT DO YOU THINK MAKES THIS PROBLEM WORSE? _____

WHAT HAVE YOU TRIED THAT DIDN'T WORK? (WHAT MEDICATIONS? HEAT? EXERCISE? DIET? REDUCE STRESS?) _____

BEFORE YOU BEGAN TO SUFFER WITH THIS PROBLEM, WAS THERE AN EARLIER ACCIDENT, INHURY, OR CONDITION THAT COULD HAVE BROUGHT THIS ABOUT OR BE RELATED TO IT? (EXAMPLE: FALL, AUTO INJURY, SPORTS TRUAMA, REPETITIVE JOB MOTION) ___ YES ___ NO DESCRIBE _____

HAVE YOU BEEN WORRIED ABOUT GETTING THIS PROBLEM HANDLED? ___ YES ___ NO

DESCRIBE HOW IT FEELS WHEN THE PROBLEM IS AT ITS WORST _____

IMAGINE A TIME WHEN THIS PROBLEM IS AT ITS WORST COMPARED TO A TIME WHEN YOU FEEL GREAT.

HOW DOES IT INTERFERE WITH YOUR:

ABILITY TO WORK? _____

ABILITY TO ENJOY OR BE WITH FAMILY (OR SOCIAL LIFE)? _____

ABILITY TO PARTICIPATE IN AND ENJOY HOBBIES? _____

ON A SCALE FOR 1-10 (10 BEING THE HIGHEST), RATE YOUR COMMITMENT TO GETTING RID OF THIS PROBLEM _____

YOUR PRIMARY CARE PHYSICIAN _____

PHONE # _____ ADDRESS _____

ARE YOU CURRENTLY UNDER ANY MEDICAL CARE? ___ YES ___ NO

FOR WOMEN: IS THERE ANY CHANCE THAT YOU ARE PREGNANT? ___ YES ___ NO

PLEASE, INDICATE LOCATION AND TYPE OF PAIN (WHERE DOES IT HURT?)

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