WITMER
CHIROPRACTIC ASSOCIATES

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Age _____ Birthday _____ Sex _____ SSN _____

◯ Single ◯ Widowed ◯ Married ◯ Divorced Number of children _____

Employer _____ Address _____ Phone _____

Occupation _____ Referred by _____

Spouse's Name _____

Occupation _____ Employer _____

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar condition in the past? _____

Is this condition getting progressively worse? ◯ Yes ◯ No ◯ Constant ◯ Comes and goes

Is this condition interfering with the following: ◯ Work ◯ Sleep ◯ Daily routine ◯ Other _____

How long has it been since you felt good? _____

List surgical operations: _____

List any prescription medications you are taking _____

_____

List any non-prescription medications: _____

Other doctors seen for this condition ☐ MD ☐ DC ☐ DO ☐ DDS ☐ PT

Doctor's name _____ Diagnosis _____

X-Rays _____ Urinalysis _____ Blood Test _____ Other _____

Treatment: Medication _____ Physiotherapy _____

HEAD:

- ☐ Headache
  - ☐ Sinus (allergy)
  - ☐ Entire head
  - ☐ Back of head
  - ☐ Forehead
  - ☐ Temples
  - ☐ Migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK:

- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasm in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

SHOULDERS:

- ☐ Pain in shoulder joints(R-L)
- ☐ Pain across shoulders
- ☐ Bursitis(R-L)
- ☐ Arthritis
- ☐ Can't raise arm
  - ☐ Above shoulder level
  - ☐ Overhead
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R-L)
- ☐ Muscle spasm in shoulders

CHEST:

- ☐ Dimpled or orange peel breasts
- ☐ Irregular heartbeat
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain

ARMS &HANDS:

- ☐ Pain in upper arm
- ☐ Pain in the elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensations of pins and needles in arms
- ☐ Sensation of pins and needles in fingers
- ☐ Numbness in arms(R-L)
- ☐ Numbness in fingers(R-L)
- ☐ Fingers fall asleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

MID BACK

- ☐ Mid back pain
- ☐ Location _____
  - ☐ Pain between shoulder blades
  - ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Muscle spasm
- ☐ Pain in the kidney area

ABDOMEN:

- ☐ Nervous stomach
- ☐ Foods can't eat _____
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

LOW BACK:

- ☐ Low back pain
  - ☐ Upper lumbar
  - ☐ Lower lumbar
  - ☐ Sacroiliac
- ☐ Low back pain is worse when:
  - ☐ Working
  - ☐ Lifting
  - ☐ Stooping
  - ☐ Standing
  - ☐ Sitting
  - ☐ Bending
  - ☐ Coughing
  - ☐ Lying down (sleeping)
  - ☐ Walking
- ☐ Pain relieve when: _____
- ☐ Slipped disc
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

HIPS & FEET

- ☐ Pain in buttocks (R-L)
- ☐ Pain in hip joint (R-L)
- ☐ Pain down leg (R-L)
- ☐ Pain down both legs
- ☐ Knee pain
  - ☐ Inside
  - ☐ Outside
- ☐ Leg cramps
- ☐ Cramps in feet (R-L)
- ☐ Pins &needles in legs (R-L)
- ☐ Numbness of leg (R-L)
- ☐ Numbness of feet (R_L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Swollen ankles (R-L)
- ☐ Swollen feet (R-L)

WOMEN ONLY:

- ☐ Menstrual pain
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle____ days
- ☐ Birth control
- ☐ Hysterectomy
- ☐ Genital cancer
- ☐ Discharge Color_____
- ☐ Tumors
- ☐ Abortions
- ☐ Menopausal
- ☐ Post-menopausal

MEN ONLY:

- ☐ Urinary frequency
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostate pain/swelling

GENERAL:

- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep_____
- ☐ Loss of sleep_____hrs/night
- ☐ Loss of weight _____lbs.
- ☐ Gain of weight _____lbs.
- ☐ Coffee_____cups/day
- ☐ Tea_____cups/day
- ☐ Cigarettes _____packs/day
- ☐ Other_____
- ☐ Diabetes
- ☐ Hypoglycemia

Remarks

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges regardless of insurance coverage.

_____

Patient, Parent, or Guardian Signature

MEDICAL HISTORY INFORMATION SHEET

Name: _____ Age: _____ Today's Date: _____

Birth Date: (M / D / Year) _____ Height: _____ ft. _____ in. Weight _____ lbs.

Reason For Today's Exam _____

PAST MEDICAL HISTORY: Please check any illnesses/conditions which YOU have had.

☐ High Blood Pressure	☐ DVT	☐ Lung Disease	☐ Stroke High
☐ Cholesterol	☐ Pulmonary Embolus	☐ Asthma	☐ Diabetes
☐ Vein Trouble	☐ Tuberculosis	☐ Heart Trouble	☐ Pneumonia
☐ Kidney Disease	☐ Nervous Disorder	☐ Seasonal Allergies	☐ HIV
☐ Thyroid Problems	☐ Sinus	☐ Arthritis	☐ Hepatitis
☐ Drug Abuse/Alcoholism	☐ Tonsillitis	☐ Gastrointestinal	☐ Osteoporosis
☐ Joint Replacement	☐ Bleeding Tendencies	☐ Cancer: If Yes, What Type _____	

Other: _____

History of Serious Injuries / Illnesses? ☐ YES ☐ NO If yes, please describe below.

_____

SURGICAL HISTORY and/or SURGICAL COMPLICATIONS? Please list

_____

_____

FAMILY MEDICAL HISTORY: Please check any illnesses/conditions immediate FAMILY has had.

☐ High Blood Pressure	☐ High Cholesterol	☐ Vein Trouble	☐ Kidney Disease
☐ Liver Disease	☐ Drug Abuse / Alcoholism	☐ Joint Replacement	☐ Osteoporosis
☐ DVT	☐ Pulmonary Embolus	☐ Tuberculosis	☐ Nervous Disorder
☐ Seizures	☐ Thyroid Problems	☐ Hepatitis	☐ Bleeding
☐ Tendencies	☐ Lung Disease	☐ Asthma	☐ Heart Trouble
☐ Seasonal Allergies	☐ Ear Problems	☐ Arthritis	☐ Gastrointestinal
☐ Stroke	☐ Diabetes	☐ Pneumonia	☐ HIV
☐ Sinus	☐ Tonsillitis	☐ Cancer: Type _____	

Other: _____

SOCIAL HISTORY:

Live Alone: ☐ Yes ☐ No

Tobacco Use: ☐ Never ☐ In the Past ☐ Presently How Much? _____ How Long? _____

Alcohol Use: ☐ Daily ☐ Occasional ☐ None Other substance use or abuse? ☐ Yes ☐ No

ALLERGIC TO LATEX: ☐ Yes ☐ No

ALLERGIC TO MEDICATIONS: ☐ No ☐ Yes - List: _____

CURRENT MEDICATIONS

SYSTEM REVIEW: Please describe any active problem or symptom.

General Symptoms (i.e. fever, weight gain/loss, fatigue) _____

Eyes/Ears/Nose/Throat _____

Allergies/Rashes _____

Endocrine (Diabetes/Thyroid)

Skin and/or Breasts _____

Heart _____

Muscles/Bones/Joints _____

Bleeding/Lymph Nodes _____

OB/Genital/Urinary _____

Lung _____

Psychiatric _____

Nerves _____

Abdomen _____