PERFORMANCE
Health Chiropractic

124 South Fairfield, Suite B
Layton, UT 84041
Tel (801) 774-0266
Fax (801) 774-9650

PATIENT HISTORY

Dear Patient: The completion of this form is a sensible first step prior to experiencing the many benefits associated with chiropractic care. This form has been designed to assist with delivering the most appropriate chiropractic care and/or identifying any possible risk factors to your health and safety to provide appropriate care and advice. Please provide the answers that represent your case to the best of your knowledge as your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

NAME_____DATE_____HOME PHONE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____ WORK PHONE_____

DATE OF BIRTH (MM/DD/YYYY) ___/___/_____AGE____ ☐M ☐F MARITAL STATUS_____ NO. OF CHILDREN_____ FAX # _____

OCCUPATION_____SSN# _____SPOUSE: _____ E-MAIL: _____

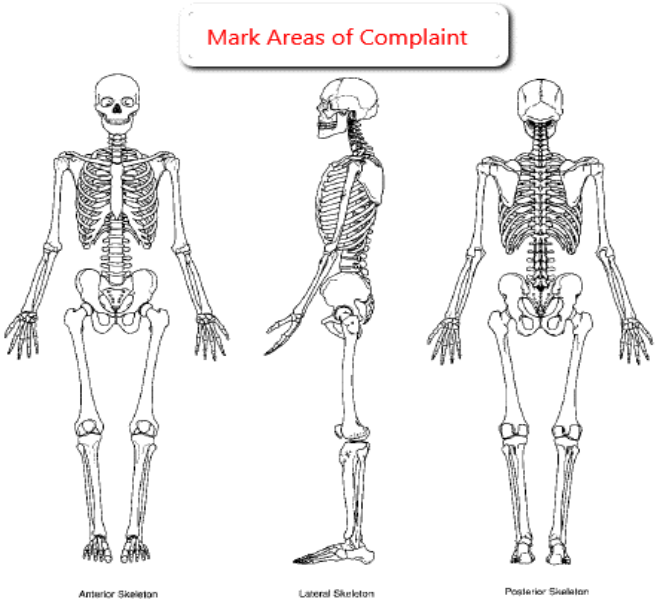
WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ REFERRED BY _____

IN CASE OF EMERGENCY (Name of relatives or close friend not living in your home):

NAME: _____ADDRESS: _____ PHONE_____

Please label the area of complaint with the following numbers:

1 = Dull **2** = Throbbing **3** = Muscle tightness **4** = Numbness **5** = Sharp ***** = Other: _____



What is your major complaint? _____

_____

_____

_____

_____

Other complaints _____

_____

_____

_____

Have you ever had previous chiropractic care? _____ If yes, date of last care _____

Do you have Health and Accident Insurance? _____ If yes, with what company? _____

Regarding your current condition:

How long have you had this condition? _____Have you had this or similar condition in the past? _____

What activities aggravate your condition? _____

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

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily routine ☐Other _____

List previous diagnoses and treatments you have received for present condition _____

_____

What do you believe is wrong with you? _____

Are you on any medications? ☐Yes ☐No Please List: _____

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for other than surgery?	☐	☐	_____
Had a motor vehicle accident or serious injury?	☐	☐	_____
Had any X-rays, CT scans, MRI, Ultrasound?	☐	☐	_____
Had any unexplained weight loss?	☐	☐	_____
Had any recent changes in a mole or freckle?	☐	☐	_____
Had any unusual lumps or swellings?	☐	☐	_____
DO YOU:			
Now take vitamins or minerals?	☐	☐	_____
Have an allergy to any drug?	☐	☐	_____

HABITS	Heavy	Moderate	Light	Past Use	None
Alcohol	☐	☐	☐	☐	☐
Coffee	☐	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	☐
Drugs	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	☐

LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE PAST 10 YEARS

_____

_____

_____

_____

_____

Below are items that may seem unrelated to the purpose of your appointment. However, please answer these items carefully as they can affect your overall course of chiropractic care. Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. REST ASSURED THAT THIS IS A CONFIDENTIAL HEALTH REPORT.

O – *Occasional* F – *Frequent* C – *Constant*

O	F	C	GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors

O	F	C	MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot Trouble
☐	☐	☐	Hernia
☐	☐	☐	Back Pain
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal curvature
☐	☐	☐	Swollen joints
☐	☐	☐	Muscle Spasms/Cramping
	Pain or numbness in:		
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Tail bone

O	F	C	GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood

O	F	C	CARDIO-VASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Swelling of ankles

O	F	C	RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing

O	F	C	SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins

O	F	C	GENITO-URINARY
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine/Stool
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control bladder
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble

O	F	C	FOR WOMEN ONLY
☐	☐	☐	Congested breast
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal menstruation
☐	☐	☐	Vaginal discharge
☐Yes	☐No		Are you pregnant?

O	F	C	EYES, EARS, NOSE, THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noise
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD?

☐Alcoholism	☐Diphtheria	☐HIV/AIDS	☐Rheumatic fever
☐Anemia	☐Eczema	☐Influenza	☐Scarlet fever
☐Appendicitis	☐Emphysema	☐Malaria	☐Stroke
☐Arteriosclerosis	☐Epilepsy	☐Measles miscarriage	☐Tuberculosis
☐Arthritis	☐Fever blisters	☐Multiple sclerosis	☐Typhoid fever
☐Cancer	☐Goiter	☐Mumps	☐Ulcers
☐Chorea	☐Gout	☐Pleurisy	☐Venereal disease
☐Cold sores	☐Heart attack	☐Pneumonia	☐Whopping cough
☐Diabetes	☐Heart disease	☐Polio	

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

ANY ADDITIONAL INFORMATION THAT YOU FEEL WOULD BE HELPFUL IN DETERMINING YOUR CONDITION

***CANCELLATIONS*:** **We ask that you respect our cancellation policy to ensure we have enough time to contact other clients on our waiting list. 24 hours' notice is required for cancellation or re-scheduling. If notice is not received, a cancellation fee will be charged.**