Scarborough Family Chiropractic

Please fill out the following information as thoroughly and honestly as possible.

Name_____ Sex: M___ F___ Date___/___/___ Email_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Place of BIrth_____ Age_____ Height_____ Weight_____

Telephone: Home ( )_____ Work ( )_____ Cell ( )_____

Single_____ Married_____ Divorced_____ Widowed_____ Living With_____

Education_____ Occupation_____

Referred By:_____

Reason for Visit Today:_____

How long have you had this condition?_____ Have you experienced this before?_____

What seemed to be the initial cause?_____

What seems to make it better?_____

What seems to make it worse?_____

Does it bother your: Sleep_____ Work_____ Other (what?)_____

Family History - Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box(es).

	self	mother	father	sibling	spouse	child
cancer or tumors						
diabetes						
blood or bleeding disorders / anemia						
seizures						
high blood pressure / heart disease						
allergies						
stroke						
drug abuse						
depression or mental illness						
age of death						
hepatitis						
kidney disorders						
thyroid disorders						
musculo-skeletal disorders						

Please put a "**X**" if the condition is current or a "**P**" if you experienced it in the past

General

__Insomnia
__Dreams / Nightmares
__Irritability
__Depression
__Mood Swings
__Fatigue
__Poor Memory
__Strongly Like Cold Drinks
__Strongly Like Hot Drinks
__Recent Weight Loss / Gain
__Cold Hands & Feet
__Chills
__Fever

Head & Neck

__Headaches
__Migraines
__Stiff Neck
__Dizziness
__Fainting
__Swollen Glands

Ears

__Ringing- High Pitch / Low Pitch
__Hearing Loss
__Infections
__Earache
__Hearing Aids
__Vertigo

Eyes

__Glasses / Contact Lenses
__Blurred Vision
__Poor Night Vision
__Spots or Floaters
__Eye Inflammation
__Double Vision
__Glaucoma
__Cataracts

Nose, Throat & Mouth

__Sinus Infection
__Hay Fever / Allergies
__Frequent Sore Throat
__Difficulty Swallowing
__Mouth & Tongue Ulcers
__Frequent Colds
__Nosebleeds
__Dry Nose
__Nasal Congestion
__Loss of Voice
__Thirst
__Excessive Phlegm
__TMJ
__Facial Pain
__Gum Problems
__Dry Mouth

Skin

__Hives
__Rashes
__Eczema / Psoriasis
__Night Sweating
__Excess Sweating
__Dry Skin
__Easy Bruising
__Changes in Moles, Lumps
__Itching

Cardiovascular

__High Blood Pressure
__Low Blood Pressure
__Chest Pain or Tightness
__Palpitations
__Rapid Heart Beat
__Irregular Heart Beat
__Poor Circulation
__Swollen Ankles
__Anemia
__History of Heart Attack

Respiratory

__Difficulty Breathing
__Difficulty Breathing Lying Down
__Wheezing
__Asthma
__Chronic Cough
__Wet Cough
__Dry Cough
__Coughing up Phlegm
__Coughing up Blood
__Shortness of Breath
__Tight Chest
__Pneumonia

Neurological

__Seizures
__Tremors
__Numbness or Tingling
__Pain
__Paralysis
__Poor Coordination
__Other (describe)

Gastrointestinal

__Nausea
__Indigestion
__Stomach Pain
__Diarrhea
__Constipation
__Poor Appetite
__Excessive Hunger
__Vomiting
__Gas
__Hiccups
__Acid Regurgitation
__Bloating
__Bad Breath
__Laxative Use
__Blood Stool
__Mucus in Stool
__Hemorrhoids

Musculoskeletal

__Joint Pain / Disorder
__Sore Muscles
__Weak Muscles
__Difficulty Walking
__Neck / Shoulder Pain
__Upper Back Pain
__Lower Back Pain
__Rib Pain
__Limited Range of Motion
__Other (describe)

Genito-urinary

__Pain on Urination
__Frequent Urination
__Urgent Urination
__Blood Urine
__Unable to Hold Urine
__Incomplete Urination
__Bedwetting
__Wake To Urinate
__Increased Libido
__Decreased Libido
__Kidney Stones
__Impotence
__Premature Ejaculation
__Nocturnal Emission
__Pain / Itching of Genitals
__Lumps of Testicles

Infection Screening

__HIV risks: Self__ or Partner__
__TB: Self___ or Household___
__Hepatitis risk: Self__ or Partner_
__History of Sexually Transmitted disease: self__ or partner__
__Gonorrhea
__Chlamydia
__Syphillis
__Genital Warts
__Herpes: oral / genital

Other:_____

_____

Personal Lifestyle Habits (how much, how many, or how often)

Cigarettes (packs)_____ Coffee / Tea (cups)_____ Alcohol (drinks per week)_____

Marijuana_____ Other Recreational Drugs _____

Vitamins & Herbs_____

Dietary Restrictions_____

Food Cravings_____

What might you eat on a typical day? Do you eat shortly before going to bed?_____

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Exercise_____ How Often?_____

What non-work activities do you enjoy doing? (reading, T.V., music, meditation, etc.)_____

_____

Medicines:

Prescription drugs you are currently taking: For what condition?

_____ _____

_____ _____

_____ _____

_____ _____

Over the Counter Medications you are currently taking: For what condition?

_____ _____

_____ _____

_____ _____

Major Hospitalizations If you have ever been hospitalized for any serious medical illness or operation, please start with the most recent one below: (do not include normal pregnancies)

Year	Operation / Illness

Date of last physical examination: _____/_____ Physicians Name_____

Physicians Address_____ Phone #: ( )_____

Have you ever been treated with acupuncture or chinese herbal medicine before?_____

Gynecology

Age of first menses:_____ Date of last menstrual period:_____ Duration of flow:_____

Blood Clots: No____ Yes____, if yes are they: Large____ Small____ Length of cycle:_____

Color of menstrual blood: Pale___ Bright Red____ Dark Red____ Purple_____ Brown_____ Other_____

Texture of menstrual blood: Thick_____ Thin_____ Watery_____ Normal_____

Pain: No____ Yes_____, if so when?_____

Irregular Periods: No___ Yes_____, if so describe:_____

PMS (describe):_____

Any other emotional upsets related to your cycle?_____

Current method of contraception:_____ Past methods?_____

Are you currently pregnant? Yes____ No_____, if no is there a chance you could be?_____

Number of Pregnancies_____ Number of Live Births_____ Number of Miscarriages_____

Number of Abortions_____ Any Premature BIrths?_____

Breast (lumps, cysts, tenderness, etc.):_____

Urinary Tract Infections:_____ How Frequent?_____

Vaginal Infections / Discharges (describe color):_____

Pain / Itching of genitalia:_____

Pap Smear: Normal_____ Abnormal_____ Date of Last Pap Smear:_____

Uterine Fibroids_____ Endometriosis_____ Other:_____

Menopause (date of onset) _____/_____ Symptoms;_____

_____

Any bleeding since?_____

Are you currently on Hormone Replacement Therapy (HRT)? Yes____ No____ Dose:_____

How long have you been on HRT?_____ Any side effects?_____

Other:_____

_____

_____

_____

_____