Peltzman Chiropractic Associates

Confidential History Form

In order to give you the highest quality care, please take a few minutes to complete the following questions about your MEDICAL HISTORY. This will become part of your permanent medical record. **Please print clearly.** Thank you.

Name: ____ Date: ______________________

CURRENT COMPLAINTS:

☐ Headaches	☐ Neck Pain	☐ Arm Pain	☐ Chest Pain
☐ Mid-Back Pain	☐ Hip Pain	☐ Leg Pain	☐ Arm/Hand Numbness
☐ Buttock Pain	☐ Low-Back Pain	☐ Leg/Foot Numbness	

☐ Other: ____

____

ONSET (How did your pain start?):

☐ Unknown ☐ Woke up with it ☐ Bending ☐ Twisting ☐ Slip/Fall ☐ Accident

Explain:____

____

____

____

PAST MEDICAL HISTORY (Please check each box if you have had the following problems.):

☐ Angina	☐ Angioplasty	☐ Arrhythmia	☐ Arthritis	☐ Asthma
☐ Bypass	☐ Cancer: where?	______________		☐ Diabetes
☐ Dialysis	☐ Diverticulosis	☐ Emphysema	☐ Hypertension	☐ Headaches
☐ Heart Attack	☐ Heart Disease	☐ Heart Failure	☐ Hemophilia	☐ Hemorrhoids
☐ High Cholesterol	☐ Impotence	☐ Kidney Stone	☐ Kidney Prob.	☐ Leg Swelling
☐ Liver Prob.	☐ Murmur	☐ Obesity	☐ Pacemaker	☐ Pass Out
☐ Pneumonia	☐ Reflux	☐ Rheumatic fever	☐ Rheumatoid	☐ Sleep Apnea
☐ Stroke	☐ Surgeries:	______________		☐ Thyroid
☐ Tuberculosis	☐ Ulcer	☐ Varicose Veins		

☐ Other: ____

FAMILY MEDICAL HISTORY

Mother:	Age: __________	☐ Living	☐ Deceased
Father:	Age: __________	☐ Living	☐ Deceased
Siblings:	Age: __________	☐ Living	☐ Deceased
	Age: __________	☐ Living	☐ Deceased

Please check each box if any family member (mother, father or siblings) has had any of the following:

☐ Angina	☐ Angioplasty	☐ Arrhythmia	☐ Arthritis	☐ Asthma
☐ Bypass	☐ Cancer: where?	______________	______________	☐ Diabetes
☐ Dialysis	☐ Diverticulosis	☐ Emphysema	☐ Hypertension	☐ Headaches
☐ Heart Attack	☐ Heart Disease	☐ Heart Failure	☐ Hemophilia	☐ Hemorrhoids
☐ High Cholesterol	☐ Impotence	☐ Kidney Stone	☐ Kidney Prob.	☐ Leg Swelling
☐ Liver Prob.	☐ Murmur	☐ Obesity	☐ Pacemaker	☐ Pass Out
☐ Pneumonia	☐ Reflux	☐ Rheumatic fever	☐ Rheumatoid	☐ Sleep Apnea
☐ Stroke	☐ Surgeries:	______________	______________	☐ Thyroid
☐ Tuberculosis	☐ Ulcer	☐ Varicose Veins		

☐ Other: ____

CURRENT MEDICATIONS: Please list all current medications below or provide us with a list of medications.

Name of Medicine	Strength	Dosage

List of known ALLERGIES:

____
____
____

TOBACCO

Type: ________________________

Year begun:___________________

Still smoking: ☐ Yes ☐ No

Year quit: ____________________

Packs per day: ________________

ALCOHOL

Type: ________________________

How often: _________________

How much: _________________

How many years:_____________

Exercise

□ None □ Light □ Moderate □ Heavy

Other:

____

____

____

____

REVIEW OF SYSTEMS: Do you (did you) have the following? (Check the appropriate boxes):

General: □ Weight gain □ Weight loss □ Fever □ Hair loss
□ Weakness □ Other: ____

Eyes: □ Eye strain □ Sensitivity to light □ Wear glasses or contact lenses

Ear, nose, throat: □ Sinusitis □ Ringing in ears □ Hearing loss □ Dizziness
□ Hoarseness □ Running nose □ Discharge or pain □ Difficulty breathing through nose
□ Painful teeth, gums or palate □ Pain or difficulty swallowing □ Growths in the mouth

Cardiovascular: □ Palpitations □ Chest pain □ Fainting □ Varicose veins
□ Dizziness □ Pain in the legs □ Cold feet/hands □ Difficulty climbing stairs
□ Shortness of breath

Respiratory: □ Spit up blood □ Shortness of breath while walking □ Asthma/wheezing
□ Cough with or without phlegm □ Other: ________________________________

Gastrointestinal: □ Abdominal pain □ Nausea □ Vomiting □ Diarrhea
□ Hemorrhoids □ Change in shape or color of stool

Genitourinary: □ Discharge □ Frequent urination □ Pain □ Pain with urination

Musculoskeletal: □ Weakness □ Back pain □ Neck pain □ Leg pain
□ Arm Pain □ Shoulder pain □ Numbness □ Headaches
□ Other: __________________________

Skin: □ Jaundice □ Dry skin □ Growths □ Pigment change
□ Moles that have changed color, shape or bleed

Neurologic: □ Numbness □ Weakness □ Tremors □ Confusion
□ Memory loss □ Other: __________________________