

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.

		Date:			
CURRENT COMPL	AINTS:				
□ Headaches	□ Neck Pain	□ Arm Pa	in □ Ch	est Pain	
□ Mid-Back Pain	□ Hip Pain	□ Leg Pai	n 🗆 Arn	n/Hand Numbness	
□ Buttock Pain	□ Low-Back F	ain □ Leg/Foo	ot Numbness		
□ Other:		-			
ONSET (How did yo	our pain start?):				
,	•	ding 🗆 Twisting 🗆 S	Slip/Fall □ Accide	ent	
	-		-		
PAST MEDICAL HIS	STORY (Please chec	ck each box if you ha	ve had the followir	ng problems.):	
PAST MEDICAL HIS	STORY (Please ched □ Angioplasty	ck each box if you ha □ Arrhythmia	ve had the followir □ Arthritis	ng problems.): □ Asthma	
□ Angina	•	•		• . ,	
□ Angina □ Bypass	□ Angioplasty	•		□ Asthma □ Diabetes	
	□ Angioplasty □ Cancer: where?	□ Arrhythmia	□ Arthritis	□ Asthma □ Diabetes	
□ Angina □ Bypass □ Dialysis	□ Angioplasty□ Cancer: where?□ Diverticulosis	□ Arrhythmia □ Emphysema	□ Arthritis □ Hypertension	□ Asthma □ Diabetes □ Headaches □ Hemorrhoids	
□ Angina □ Bypass □ Dialysis □ Heart Attack	□ Angioplasty□ Cancer: where?□ Diverticulosis□ Heart Disease	□ Arrhythmia □ Emphysema □ Heart Failure	□ Arthritis□ Hypertension□ Hemophilia	□ Asthma □ Diabetes □ Headaches □ Hemorrhoids	
□ Angina□ Bypass□ Dialysis□ Heart Attack□ High Cholesterol	□ Angioplasty□ Cancer: where?□ Diverticulosis□ Heart Disease□ Impotence	□ Arrhythmia □ Emphysema □ Heart Failure □ Kidney Stone	□ Arthritis□ Hypertension□ Hemophilia□ Kidney Prob.□ Pacemaker	□ Asthma □ Diabetes □ Headaches □ Hemorrhoids □ Leg Swelling	
□ Angina□ Bypass□ Dialysis□ Heart Attack□ High Cholesterol□ Liver Prob.□ Pneumonia	 □ Angioplasty □ Cancer: where? □ Diverticulosis □ Heart Disease □ Impotence □ Murmur 	□ Arrhythmia □ Emphysema □ Heart Failure □ Kidney Stone □ Obesity	□ Arthritis□ Hypertension□ Hemophilia□ Kidney Prob.□ Pacemaker	□ Asthma □ Diabetes □ Headaches □ Hemorrhoids □ Leg Swelling □ Pass Out	
□ Angina□ Bypass□ Dialysis□ Heart Attack□ High Cholesterol□ Liver Prob.	 □ Angioplasty □ Cancer: where? □ Diverticulosis □ Heart Disease □ Impotence □ Murmur □ Reflux 	□ Arrhythmia □ Emphysema □ Heart Failure □ Kidney Stone □ Obesity	□ Arthritis□ Hypertension□ Hemophilia□ Kidney Prob.□ Pacemaker	□ Asthma □ Diabetes □ Headaches □ Hemorrhoids □ Leg Swelling □ Pass Out □ Sleep Apnea	

FAMILY ME	JICALI	11010111				
Mother: Age:		□ Living □ Deceased				
Father:			□ Living □ Deceased			
Siblings:	Age:		□ Living □ Deceas	ed		
	Age:		□ Living □ Deceas	ed		
Please check	k each l	oox if any family men	nber (mother, father o	or siblings) has had	d any of the following:	
□ Angina		□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma	
□ Bypass		□ Cancer: where?			□ Diabetes	
□ Dialysis		□ Diverticulosis	□ Emphysema	□ Hypertension	□ Headaches	
□ Heart Attac	ck	□ Heart Disease	□ Heart Failure	□ Hemophilia	□ Hemorrhoids	
□ High Chole	esterol	□ Impotence	□ Kidney Stone	□ Kidney Prob.	□ Leg Swelling	
□ Liver Prob.		□ Murmur	□ Obesity	□ Pacemaker	□ Pass Out	
□ Pneumonia	а	□ Reflux	□ Rheumatic fever	□ Rheumatoid	□ Sleep Apnea	
□ Stroke		□ Surgeries:			□ Thyroid	
□ Tuberculos	sis	□ Ulcer	□ Varicose Veins		_	
□ Other:						
					_	
OUDDENT A	455104	TIONIO DI LI I	п с е е		c	
		TIONS: Please list a	all current medications	s below or provide	us with a list of	
medications.						
Name of Medicine		diaina	Ctropoth		Decem	
	e or ivied	dicine	Strength		Dosage	
	e or ivied	dicine	Strength		Dosage	
	e or ivied	dicine	Strength		Dosage	
	e or ivied	dicine	Strength		Dosage	
	e or ivied	dicine	Strength		Dosage	
	e or ivied	dicine	Strength		Dosage	
	e or ivied	dicine	Strength		Dosage	
	e or ivied	dicine	Strength		Dosage	
			Strength		Dosage	
List of known			Strength		Dosage	
List of known			Strength		Dosage	
List of known			Strength		Dosage	
List of knowr			Strength		Dosage	
					Dosage	
TOBACCO	n ALLEF	RGIES:	ALCOHO			
TOBACCO Type:	n ALLEF	RGIES:	ALCOHO Type:			
TOBACCO Type: Year begun:	n ALLEF	RGIES:	ALCOHO Type: How ofter	າ:		
TOBACCO Type: Year begun: Still smoking	: ¬Ye	RGIES:	ALCOHO Type: How ofter How muc	า: h:		
TOBACCO Type: Year begun: Still smoking Year quit:	: □Ye	RGIES:	ALCOHO Type: How ofter How muc	າ:		

Exercise					
□ None	□ Light □ Moder	ate 🗆 Heavy			
Other:					
REVIEW OF	SYSTEMS: Do you (di	d you) have the follow	ing? (Check the a	appropriate boxes):	
		□ Weight loss		□ Hair loss	
Eyes:	□ Eye strain	□ Sensitivity to light	□ Wear glasses	or contact lenses	
Ear, nose, the	roat: □ Sinusitis	□ Ringing in ears	□ Hearing loss	□ Dizziness	
□ Hoarseness	□ Running nose	□ Discharge or pain	□ Difficulty breathing through nose		
□ Painful teeth	n, gums or palate	□ Pain or difficulty sw	allowing	□ Growths in the mouth	
Cardiovascular: □ Palpitations		□ Chest pain	□ Fainting	□ Varicose veins	
□ Dizziness □ Pain in the legs		□ Cold feet/hands □ Difficulty climbing stairs		oing stairs	
□ Shortness o	f breath				
Respiratory: □ Spit up blood			•	•	
□ Cough with	or without phlegm	□ Other:			
Gastrointesti	<i>nal:</i> □ Abdominal pair	n □ Nausea	□ Vomiting	□ Diarrhea	
□ Hemorrhoid	s □ Change in shap	pe or color of stool			
Genitourinar	y: □ Discharge	□ Frequent urination	□ Pain	□ Pain with urination	
Musculoskel	e tal: □ Weakness	□ Back pain	□ Neck pain	□ Leg pain	
	·	□ Numbness	□ Headaches		
□ Other:					
Skin: □ Jaur □ Moles that h	dice □ Dry ave changed color, sł		wths □ Piç	gment change	
Neurologic:	□ Numbness	□ Weakness	□ Tremors	□ Confusion	
□ Memory loss		□ Other:			