



AM Chiropractic, P.L.L.C.

Dr. Ammie Chapman, D.C.

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PATIENT HEALTH HISTORY

Date: _____ Patient Name _____ Patient Id #: _____

Describe your reason for visit _____

Which of the following symptoms you are experiencing: O aching pain O shooting pain O numbness
O tingling O weakness O stiffness O throbbing O swelling O burning O cramping

O other: _____

Mark an X in the area (s) where you experience your symptoms:

When did your symptoms appear?

Are your symptoms constant or do they come and go?

How often do you experience your symptoms (daily, once a week, etc)?

When you are symptomatic; how long until the symptoms subside (20min)?

How are your symptoms changing (getting better, staying the same, getting worse)?

Rate the severity of your symptoms from 0 (no pain) to 10 (most severe pain imaginable)

At their worst: 1 2 3 4 5 6 7 8 9 10

At their best: 1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities:

0 1 2 3 4 5 6 7 8 9 10
no complaints mild, forgotten moderate, interferes Limiting prevents Severe,
with activity with activity full activity no activity

What activities make them better? _____

What activities make them worse? _____

What treatment have you received for this condition? _____

Name and contact information of other doctors who have treated you for this condition? _____

Have you had similar symptoms in the past? _____

If yes, please describe: _____

Have you seen a chiropractor before? _____ Who? _____ When? _____

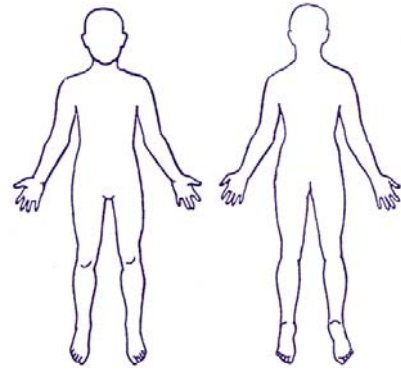
For what reason? _____

Where you happy with your care? _____ Why/ Why not? _____

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Other X-Ray _____ Urine Test _____

MRI,CT, Bone Scan _____





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Describe the type and amount of exercise you get:	Describe how you spend most of your time at work: Interests/Hobbies:	Habits: O Smoking Packs/Day _____ Years _____ O Alcohol Drinks/Week _____ O Coffee Cups/Day _____ O High Reason _____ Stress
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Height: _____ Weight: _____ Weight one year ago: _____

When during the day is your energy and alertness best? _____ Worst? _____ Hours of Sleep at night? _____

List any known diet restrictions _____

Do you have any current dietary concerns? _____

Any bowel or bladder concerns? _____

MEDICATIONS/CONTRACEPTIVE:	ALLERGIES:	VITAMINS/HERBS/SUPPLEMENTS:
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When was the first date of your last menstrual period? _____ Do you have regular menses? _____

Are you pregnant? Yes No Due Date _____

List any past trauma:	List any past surgeries/hospitalizations:	List any major past illnesses:
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Family History: Do you have a family history of any of the following diseases or conditions? When answering, include your parents, brother/sisters, and grandparents, if known. Check all that apply.

- O Anemia O Cancer O Heart Disease O Mental Illness O Alzheimer's O Arthritis
- O Diabetes O Hypertension O Multiple Sclerosis O Stroke O Asthma O Epilepsy
- O Kidney Disease O Parkinson's O Other: _____