



PATIENT HEALTH HISTORY

PLEASE ANSWER ALL QUESTIONS FULLY TO HELP THIS OFFICE SERVE YOU BETTER

NAME _____ HOME PHONE _____

MAILING ADD _____ STREET ADD _____
CITY _____ STATE _____ ZIP _____

SS# _____ DATE OF BIRTH _____ AGE _____ AGE OF CHILD _____

YOUR OCCUPATION _____ NAME OF COMPANY _____
If retired, what did you do?

WORK PHONE _____ CELL PHONE _____

MARTIAL STATUS S M W Sep SPOUSES NAME _____
SPOUSES OCCUP _____ NAME OF COMPANY _____

WE HAVE INFORMATION TO GIVE YOU TO HELP YOU UNDERSTAND YOUR CONDITION AND HEAL MORE QUICKLY. DO YOU PREFER REGULAR MAIL OR EMAIL?
YOUR E-MAIL ADDRESS _____

EMERGENCY CONTACT name and phone number _____

WHO CAN WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

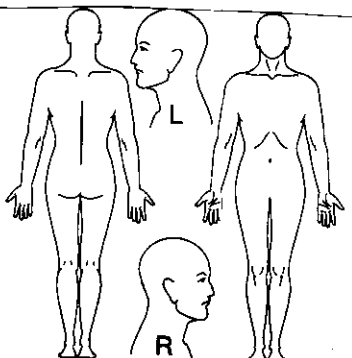
LOCAL DOCTOR's name? _____ LAST EXAM DATE _____

TREATMENTS IN THE LAST YEAR? _____

WHAT CAN WE HELP YOU WITH? _____

DESCRIBE WHAT YOU ARE FEELING BY MARKING THE INVOLVED BODY PARTS, using the symbols below

- numbness xxxxxx
- pins & needles.....
- burning 000000
- aching ^^^^^^^
- stabbing //////////////



MARK THE LEVEL OF PAIN YOU ARE IN 1-----10
Less pain Most pain

HOW AND WHEN DID IT FIRST DEVELOP? _____

HOW IS YOUR LIFE AFFECTED BY THIS PAIN? Sitting Standing Lifting Sleeping
Walking Driving Reaching Carrying Squatting Other _____
WHAT RELIEVES THE PROBLEM? Medication Ice Heat Exercise Rest Other _____

WHAT DRUGS DO YOU TAKE _____
WHAT VITAMINS DO YOU TAKE _____

TREATED FOR THIS IN THE PAST? YES BY WHOM _____ RESULTS _____

CIRCLE ANY THAT APPLY FOR THE LAST 12 MONTHS or I HAVE NONE OF THESE SYMPTOMS

| | |
|---------------------------|---|
| Bladder/digestion changes | Ear ring/buzz |
| Weakness in arms/legs | Joint swelling |
| Shortness of Breath | Persistent fever |
| Nagging cough/hoarseness | Recurring headaches |
| Slurring of speech | Vascular problems/hot/cold/swelling arms/legs |
| Frequent illness | Problems with memory |
| Muscle spasms | Numbness/tingling arms/legs/hands/feet |
| Fatigue/Insomnia | Loss of smell or taste |
| Anxiety/depression | |

PLEASE circle ALL THAT APPLY TO YOU OVER YOUR entire life AND GENERAL DATES.

AUTO ACCIDENTS _____ **SURGERIES** _____
TRAUMA/FALLS _____ **BROKEN BONES** _____
CONTACT SPORTS _____ **SERIOUS ILLNESS** _____ **SMOKER**
ALCOHOL _____ **HEAVY LIFTING JOBS** _____
DO YOU WEAR A SEAT BELT REGULARLY? Yes No Sometimes _____

I give permission for the doctor to examine me and do all tests necessary, for my treatment at Latimer Chiropractic Total Wellness Center

PATIENT SIGNATURE _____ **DATE** _____

PEDIATRIC INFO

BIRTH INFO: ANY DIFFICULTIES OR DELAYS DURING LABOR? _____
BIRTH WEIGHT _____ **HEIGHT** _____
NAME OF PARENT OR GUARDIAN _____ **HOME PHONE** _____
DIET INFO: AVERAGE BREAKFAST _____
LUNCH _____
DINNER _____
ANY DIGESTIVE/SKIN/BEHAVIORAL SYMPTOMS? _____

I hereby authorize Pamela G. Latimer, D.C. and whomever she may designate to administer care as is deemed necessary to my son/daughter/ward.

PARENTS SIGNATURE _____ **DATE** _____
WITNESSED _____