Schwenn Family Chiropractic

Welcome to Schwenn Family Chiropractic. Please complete the following review of your bodily systems.
While these conditions may not seem directly related to the reason you are here,
this information will help the doctor get a better idea of your overall health past and present.
Please check any conditions that you have presently or have had in the past.

Name:_____ **Date:**_____

Childhood Illensses:

___ADD ___Allergies ___Anemia ___Asthma ___Bedwetting ___Cerebral Palsy ___Diabetes
___Ear Infections___Fetal Drug Exposure ___ Food Allergies- _____
___Headaches ___Measles ___Mumps ___Psoriasis ___Scoliosis ___Seizures ___Spina Bifida

Adult Illnesses:

___Alzheimer's ___Anemia ___Arthritis ___Asthma ___Cancer ___Crohn's/colitis ___CVA(stroke)
___Cystic kidney disease ___Depression ___Diabetes (insulin dep/non insulin dep) ___Excema
___Emphysema ___Eye Problems ___Fibromyalgia ___Heart Disease ___Hepatitis ___HIV
___Hypertension ___Liver disease ___Lung disease ___Lupus ___Multiple Sclerosis ___Parkinson's
___Pneumonia ___Psoriasis ___Psychiatric concerns ___Scoliosis ___Seizures ___Shingles
___STD ___Suicide attempt(s) ___Thyroid problems ___Vertigo ___Other:_____

Injuries: *(Please list date and explanation)*

___Back injury ___Broken Bones ___Head injury ___Loss of consciousness ___Industrial accident
___Joint injury ___Auto Accident(Date(s)_____ ___Laceration
___Other:_____
Explanation_____
_____

Surgeries: (Please list any surgeries you have had and date)

_____
_____
_____

Medication & Vitamins:

Vitamin/Medication name	Reason	Rx/ Non Rx	Date began	Date stopped	Prescribed by Dr. or Self

Females ONLY:

Pregnancy History:
___# of complicated pregnancies ___# of uncomplicated pregnancies _____# of C-Sections
___# of Vaginal deliveries ___# of miscarriages ___# of terminated pregnancies

Menstrual History:
My Menses are ___Regular ___Irregular ___Age of first menses ___Age when menopause began

Pregnancy Release

This is to verify to the best of my Knowledge I am NOT pregnant. I give Schwenn Family Chiropractic permission to perform an x-ray evaluation if it is clinically beneficial to my care. I have been advised against having an x-ray Evaluation if there is any chance that I may be pregnant.

1st day of last menstrual cycle_____

Signature_____Date_____

over

Patient History

Your Main Complaint_____Date of Onset_____
Result of a Trauma? Yes / No Severity 1-10 *(10 is worst)*_____ % of time:_____
Lost work days? Yes / No How many?_____ When do you notice it most? AM / PM
What makes it Better?_____Worse?_____
Type of Pain~ Sharp Dull Aching Burning Throbbing Cramping Numbness Tingling Other:_____

Accident related? Yes / No Auto / Work Date of incident:_____Similar condition before? Yes / No Date:_____

Do you have any Pain and/or Difficulty performing any of the following activities: *(Circle all that apply)*
Personal care - Lifting - Reading - Working - Driving - Walking - Sitting - Standing - Social Life - Exercise

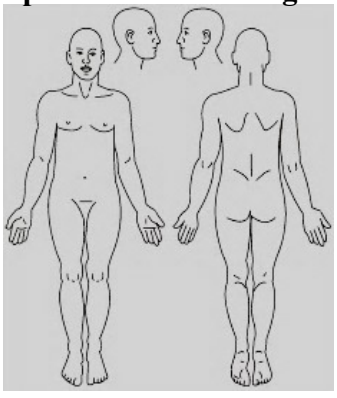
Previous Chiropractic Care? Yes / No Name of Dr._____Date of last adjustment_____

Was spinal maintenance recommended? Yes / No Did you follow recommendations? Yes / No If No Why? _____
Reason for changing Chiropractors_____
What are your Health Goals? _____
How do you expect to achieve them?_____

Family History:

General Family	___Alive	___Deceased	___No significant disease	___Has/Had_____
Father	___Alive	___Deceased	___No significant disease	___Has/Had_____
Mother	___Alive	___Deceased	___No significant disease	___Has/Had_____
Paternal Grandfather	___Alive	___Deceased	___No significant disease	___Has/Had_____
Paternal Grandmother	___Alive	___Deceased	___No significant disease	___Has/Had_____
Maternal Grandfather	___Alive	___Deceased	___No significant disease	___Has/Had_____
Maternal Grandmother	___Alive	___Deceased	___No significant disease	___Has/Had_____
Son (s)	___Alive	___Deceased	___No significant disease	___Has/Had_____
Daughter(s)	___Alive	___Deceased	___No significant disease	___Has/Had_____
Brother(s)	___Alive	___Deceased	___No significant disease	___Has/Had_____
Sister(s)	___Alive	___Deceased	___No significant disease	___Has/Had_____

Please mark areas of pain on the drawing



Please mark if you have or have had any of the following:

Eyes/Vision:
___Blurred vision
___Cataracts
___Double vision
___Glaucoma
___Light sensitivity

Gastrointestinal:
___Abdominal pain
___Diarrhea
___Constipation
___Heartburn
___Nausea
___Vomiting
___Vomiting Blood

Blood:
___Bruise easily
___Clotting problems
___Blood Transfusion
___Fatigue

Ears, nose, throat:
___Difficulty swallowing
___Dizziness
___Ear Pain
___Frequent sore throats
___Headaches
___Hearing Loss
___Head injury
___Hoarsness
___Loss of smell
___Nasal Congestion
___Nosebleeds
___Sinus infections
___Snoring
___Ringing in ears
___TMJ Problems

Respiration:
___Coughing up blood
___Wheezing
___Shortness of breath

Cardiovascular:
___Chest pain
___Leg pain
___Heart Murmur
___High Blood Pressure
___Varicose veins
___Swelling of legs
___Low Blood Pressure

Nervous system:
___Facial weakness
___Loss of balance
___Loss of memory

Male/Female concerns:
___Prostate problems
___Breast Lumps/pain
___Erectile Dysfunction

Endocrine and Skin:
___Excessive hunger
___Excessive thirst
___Hair loss or growth
___Intolerance to cold or heat
___Frequent urination
___Itching
___Change in skin color

Psychological:
___Anxiety
___Depression
___Insomnia
___Behavioral change
___Confusion
___Bi-polar disorder

Please list anything else that you feel may be relevant to your care:

_____

_____

The above information is complete and accurate to the best of my knowledge

Signature_____Date_____