LifeSpring Chiropractic

Past Health History

Please mark the appropriate box for any current [✓] or previous [✖] health conditions

Musculoskeletal
- ☐ Auto Accidents
- ___0-1 years ago
- ___1-5 years ago
- ___More than 5
- ☐ Fractured Bones
- ☐ Pain/Stiff Neck R L
- ☐ Upper Back Pain/Stiffness
- ☐ Mid Back Pain/Stiffness
- ☐ Numbness, Tingling or Pain in
- ☐ Numbness/Tingling/Pain Arms/Hands/Fingers R or L
- ☐ Swollen/Painful Joints
- ☐ Difficulty in Excessive Standing, Walking, Bending, Riding, Twisting, Lifting, Household Duties
- ☐ Other Accidents/Falls
- ☐ Back Curvature
- ☐ Low Back
- ☐ Shoulder Pain R / L
- ☐ Arthritis
- ☐ Jaw Pain/TMJ R / L
- ☐ Foot Trouble R / L
- ☐ Hip Pain R / L

Neurological
- ☐ Convulsions/Epilepsy
- ☐ Learning Disability
- ☐ Loss of Balance
- ☐ Dizziness
- ☐ Ringing in Ears R / L
- ☐ Trouble Concentrating
- ☐ Irritable
- ☐ Fainting
- ☐ Hearing Lost R /L
- ☐ Tremors
- ☐ Double Vision R / L
- ☐ Trouble Sleeping
- ☐ Blurred Vision R / L
- ☐ Mood Changes
- ☐ Headache
- ☐ Pain with cough, sneeze
- ☐ Depressed
- ☐ Eating Disorders

Digestive
- ☐ Diarrhea/Constipation
- ☐ Heartburn
- ☐ Colon Trouble
- ☐ Gall Bladder Trouble
- ☐ Diabetes
- ☐ Ulcers
- ☐ Hemorrhoids

Immune
- ☐ Frequent Colds/flu
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Ear Infection
- ☐ Allergies
- ☐ Cancer
- ☐ AIDS/HIV

Other Systems
- ☐ Kidney Trouble
- ☐ Chest Pain
- ☐ Lung Problems
- ☐ Heart Problems
- ☐ Liver Trouble
- ☐ High/Low Blood Pressure
- ☐ Head/Shoulders Feel Tired
- ☐ Stroke
- ☐ Anemia
- ☐ Prostate Problems
- ☐ Impotence
- ☐ Skin Problems
- ☐ Thyroid Problems
- ☐ Varicose Veins
- ☐ Bed Wetting
- ☐ Menopausal Problems
- ☐ Menstrual Problems/PMS
- ☐ Pregnant (now)

2. PLEASE, identify ALL PAST and any **CURRENT** conditions you feel may be contributing your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
PREVIOUS ACCIDENTS:			
INJURIES :			
SURGERIES:			
CHILDHOOD DISEASES:			
ADULT DISEASES:			

Social History

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug Use ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

4. Hobbies -Recreational Activities- Exercise Regime: How does you present problem affect the following:

IDENTIFY TYPE:	EFFECT:
______________________________	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
______________________________	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
______________________________	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform

5. Work Activities: Please complete all questions!

Hours worked per day: _____ Days per week: _____ Does your job require lifting? ☐No ☐Yes If yes, what is the maximum required? ☐ Min (<5 lbs) ☐ Light (5-20 lbs) ☐ Med (20-50lbs) ☐ Hvy (>50 lbs)

Lifting Frequency: ☐ Constant (66-100%of day) ☐ Frequent (33-66% of day) ☐ Occasional (0-33% of day)

Lifting Postures: ☐ Knee ☐ Torso ☐ Arm ☐ Shoulder ☐ Off Posture

Standing: _____ Hrs per day Sitting: _____ Hrs per day Pushing: ______ Hrs per day
Twisting: _____ Hrs per day Climbing: _____ Hrs per day Pulling: ______Hrs per day
Kneeling: _____ Hrs per day Reaching: _____ Hrs per day Walking: ______Hrs per day

6. Repetitive Activities:

Computer: _____ Hrs per day Grasping: _____ Hours per day Hand Tools: _____ Hrs per day
Machinery: _____ Hrs per day Assembly: _____ Hrs per day Phone: _____ Hrs per day
Other: ______________________________ _____ Hrs per day

7. Impact of Current Condition on Work Capacity: ☐ No Effect ☐ Painful ☐ Limits ☐ Unable to work

8. **How** many years of school did you complete? ❑ 1-8 ☐ 8-12 ☐12-14 ☐14-16 ☐ 16 +

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FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)

Have they ever been treated for their condition? ❑ No ❑ Yes ❑I don't know

2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: ______________________________

ACTIVITIES OF DAILY LIVING

ACTIVITY	No Pain	Mild Pain	Tolerable Pain	Moderate Pain	Severe Pain	Disabling Pain
Walking	☐	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐	☐	☐
Lifting	☐	☐	☐	☐	☐	☐
Running	☐	☐	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐	☐	☐
Carrying	☐	☐	☐	☐	☐	☐
Pushing	☐	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐
Reading	☐	☐	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐	☐	☐
Household Chore	☐	☐	☐	☐	☐	☐
Gardening	☐	☐	☐	☐	☐	☐
Sports	☐	☐	☐	☐	☐	☐
Working	☐	☐	☐	☐	☐	☐
Dancing	☐	☐	☐	☐	☐	☐
Sitting to Standing	☐	☐	☐	☐	☐	☐
Rolling Over	☐	☐	☐	☐	☐	☐
Doing Computer Work	☐	☐	☐	☐	☐	☐
Shoveling	☐	☐	☐	☐	☐	☐

I hereby authorize payment to be made directly to ***Lifespring Chiropractic****, for all benefits that may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to* ***Lifespring Chiropractic***

______________________________ ______________________

Patient Signature **Date Completed**