

**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:
_____	<input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
_____	<input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
_____	<input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> 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 +

**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	Duration of Activity (minutes)
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Household Chore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gardening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sitting to Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rolling Over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Doing Computer Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shoveling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Performing Sexual Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Estimated capacity of loads that cause any pain during Activities of Daily Living (in lbs): \_\_\_\_\_



*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**