



Patient Medical History

9711 Skokie Blvd. Suite F
Skokie IL, 60077
Ph. 773.282.4300

Personal Information

First Name: _____

Last Name: _____

Date: ____/____/____ (MM/DD/YYYY)

DOB: ____/____/____ (MM/DD/YYYY)

Sex: _____

Chief Complaint

What is your reason for seeing us? _____

Date of Injury / Onset of Symptoms: _____

Main Problem : Pain Numbness Weakness

(Check all that apply) Unstable Weakness Popping/Grinding
 Stinessness Other: _____

Where did the injury/complaint occur:

Work Home Sports/Recreation
 School Car Crash
 Other: _____

Severity/Intensity of pain:

(1: No pain; 10: Worst pain ever)

1 2 3 4 5 6 7 8 9 10

Quality of pain:

Sharp Stabbing Aching Tingling
 Numb Dull Burning Radiating
 Throbbing Cramping

Date: ____/____/____

Pt. Last Name: _____

Pt. First Name: _____

DOB: ____/____/____ (MM/DD/YYYY)

Previous/Current treatment for complaint: **None**

(Check all that apply)

Therapies: Chiropractic Physical Therapy Injections

Other: _____

Medications: Pain Medication Muscle Relaxants Anti-inflammatory

Other: _____

Imaging: MRI CT Scan X-Ray

Other: _____

Are you pregnant? Yes NO

Medical History

Do you have any of the following conditions: **None**

(Check all that apply)

Abnormal Heart Rhythm

Acid Reflux

Alcoholism/Drug Abuse

Anxiety/Bipolar

Asthma

Bladder/Bowel Problems

Bleeding Disorder

Blood Clots

Bronchitis

Cancer: _____

COPD

Depression/Suicidal

Goiter

Gout

Heart Attack

Heart Disease

Heart Failure

Hepatitis

High Blood Pressure

High Cholesterol

HIV/AIDS

Hypothyroidism

Kidney Disease/Issues

Metal Implants

Migraines

Osteoarthritis

Osteoporosis

Pacemaker

Pneumonia

Psoriatic Arthritis

Reactive Arthritis

Rheumatoid Arthritis

Seizures

Sexual Dysfunction

Sleep Apnea

Stomach Ulcers

Stroke

Other: _____

Date: _____ / _____ / _____

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Review of Symptoms

Are you experiencing any of the following? (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pain with urination |
| <input type="checkbox"/> Behavior change | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Bloody Stool | <input type="checkbox"/> Fever | <input type="checkbox"/> Redness of skin |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Chest palpitations | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Sleep disturbance |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Stomach pain |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Lightheaded | <input type="checkbox"/> Sweating |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Swollen: _____ |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Temperature intolerance |
| <input type="checkbox"/> Difficulty with balance | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
|
 | | |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Nodules/Bumps on skin | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Numbness | <input type="checkbox"/> None apply |

Previous Surgeries

Have you had any previous surgeries? If so, please include date and type of surgery.

None

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Medications

Please list any prescriptions, over-the-counter medication, vitamins, or supplements being taken.

None

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Date: ____ / ____ / ____

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Allergies

Do you have any allergies? If so, please include what type.

None

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Family History

Please indicate if you have a family history of any of the following, and your relation to the person. *(Check all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Arthritis: _____ | <input type="checkbox"/> Hypertension _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Migraines _____ |
| <input type="checkbox"/> COPD _____ | <input type="checkbox"/> Scoliosis _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> High Cholesterol _____ | |

Social History

(Check all that apply)

Occupation: _____ Full Time Part Time Unemployed

Do you use tobacco products? If yes, how much do you smoke per day, and for how long?

- No
- Former Smoker. Packs per day: _____ Number of years: _____
- Current Smoker. Packs per day: _____ Number of years: _____

Do you consume alcoholic products?

- No
- Occasionally. Number of drinks per week: _____
- Daily. Number of drinks per week: _____

Date: _____ / _____ / _____

Pt. Last Name: _____

Pt. First Name: _____

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What is your marital status?

- Single
- Married
- Divorced

Do you exercise? If so, what types of activities, and how often?

- No
- Occasionally. Type of exercise: _____ How often: _____

Daily. Type of exercise: _____ How often: _____

How much do you sleep each day on average? _____

Signature of patient, parent, or guardian

Date

Physician's Signature

Date

Name of Person completing this form

For Staff to complete

Vitals

BP: _____ mm Hg L / R

HR: _____ bpm

RR: _____ cpm

Temp: _____ °F / °C

Ht.: _____ Ft. / cm.

Wt.: _____ lb. / kg.

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