South Lyon Chiropractic
327 N. Lafayette, South Lyon MI 48178
(248) 491.6776

CONFIDENTIAL HEALTH HISTORY

Today's Date: _____ How did you hear about South Lyon Chiropractic? _____

Have you consulted a chiropractor before? O No O Yes Whom? _____ When? _____ Why? _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____
Street, Apt # City, State Zip Code

Cell Phone: __(_____)_____ Home Phone: __(_____)_____

Email Address: _____ Age: _____ Birth date: _____

Insurance Company: _____

Marital Status: O Single O Currently in a Relationship O Married O Divorced O Widowed O Separated
Number of Children: _____ Children's Name & Ages: _____
Emergency Contact Name: _____ Relationship:_____ Phone #: _____

Your Occupation: _____Your Employer: _____ Work Phone: _____

PAST MEDICAL HISTORY

Is your visit due to an **accident**, **injury** or **trauma**? O No O Yes - If so, was it: O Auto O Work - Please Explain:_____

List any **accidents**, **injuries** or **traumas** you have experienced: _____

List any **surgeries** or major **illnesses**: _____

List any major **allergies**: _____

Have you ever been to an **emergency room**? O No O Yes – explain: _____

Have you ever been **admitted** to a **hospital**? O No O Yes – explain: _____

What **medications** and/or **vitamins** are you taking?_____

Do you **carry medication** in case of an emergency? O No O Yes – explain: _____

Has a physician treated you for any **health condition** in the past year? O No O Yes - Please explain: _____

Diagnostic Imaging: O X-Ray O MRI O CAT Scan When? _____ Where? _____

Do you have any **implanted medical devices** or **imbedded foreign objects**? O No O Yes - _____

Have you ever been fitted for a special **brace**, worn a **brace** or worn a **cast**? O No O Yes - _____

When was your **last physical exam**? _____ - Normal? O No O Yes **Primary Doctor Name & Location**: _____

FEMALES: Do you see a gynecologist regularly? O No O Yes

MALES: Do you have a Prostate Exam regularly? O No O Yes

Are you in good **overall health**? _____ **High Blood Pressure**? O No O Yes **Last Check?** _____

FAMILY HISTORY

Any major **illnesses** in your **family**? O No O Yes: O **Heart Disease** O **Stroke** O **Diabetes** O **Cancer** O Other: _____

SOCIAL HISTORY

Do you have any special **dietary** habits? O No O Yes: _____ Exercise?_____

Do you **smoke**? O YES O NO Do you drink? O Yes O No What are your **hobbies**? _____

What is the major **stressor** in your life_____ Hours of **sleep** per night: _____ **Sleeping position**? _____

CURRENT CONDITION

1. The **symptom**(s) that have prompted me to seek care today include: _____

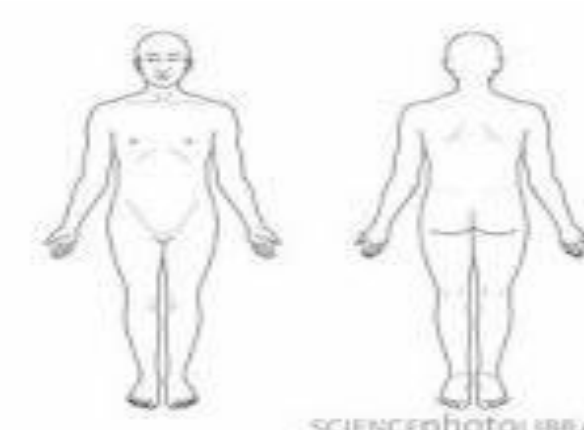
2. **Onset** (When did you first notice your current symptom(s)): _____

3. **Intensity**: (How extreme are your current symptoms?) **0** O—O—O—O—O—O—O—O—O—O **10**
Absent Uncomfortable Agonizing

4. **Duration and Timing:** (When did it start & how often do you feel it?) O Constant O Comes & Goes How Often? _____

5. **Feels?** O Numbness O Tingling O Stiffness O Dull O Aching O Cramps O Nagging O Sharp O Burning O Shooting
O Throbbing O Stabbing O Other: _____

6. **Location** (Where does it hurt?)



7. **Radiation** (What areas does the pain go?):_____

8. What tends to **worsen** this problem? _____

9. What tends to **lessen** the problem? _____

10. **Prior interventions** (what have you done to try and relieve the symptoms)

O Prescription Medication	O Surgery	O Ice
O Over-the-Counter Drugs	O Acupuncture	O Heat
O Homeopathic Remedies	O Chiropractic	O Physical Therapy
O Massage	O Other: _____	

11. Additional **Questions** about your condition.

- Is your pain/problem worse at night? ---------- O No O Yes O N/A
- Does your pain/problem improve with bed rest? ---------- O No O Yes O N/A
- Does the current pain/problem awaken you after falling asleep? ---------- O No O Yes O N/A
- Is the following statement **true** regarding your pain/problem:
  - *"there is no position that relieves my pain/problem"* ---------- O No O Yes O N/A
- Do you notice any other symptoms, areas of weakness or sensations? -- O No O Yes O N/A

Acknowledgements - Please read the statement and sign your agreement.
To the best of my ability, the information I have supplied is complete and truthful.
I have not misrepresented the presence, severity, or cause of my health concern.

Print Name **Signature** **Date**