# Helping Hands Chiropractic History Form

*First Name:* _____ *Last Name:* _____ *MI:*_____ *Date* _____

*Address:* _____ *Apt/Unit:* _____

*City:* _____ *State:* _____ *Zip Code:* _____

*Primary Phone:* _____ *Cell Phone and Carrier:* _____

*Email Address:* _____ *Birthdate:* _____ *Referred by* _____

**What is/are your current symptom(s) / pain(s)**: _____

**How long have you had your pain? When did your pain flare up?** _____

**How did this problem begin**? _____

**Is your current injury/condition related to an auto/work accident? Yes☐ No☐ If yes, what is the date of the accident?** _____

**Please describe your current pain**

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting

☐ Burning ☐ Tingling ☐ Other_____

**Since your pain flared up or started, is the pain….**

☐ Increasing ☐ Decreasing ☐ Not Changing ☐ Comes and goes

**How frequent is your pain?** ☐ Daily ☐ Weekly ☐ Monthly

**Do you feel the pain?**

☐ All the time ☐ Most of the time ☐ Some of the time ☐ Comes and goes

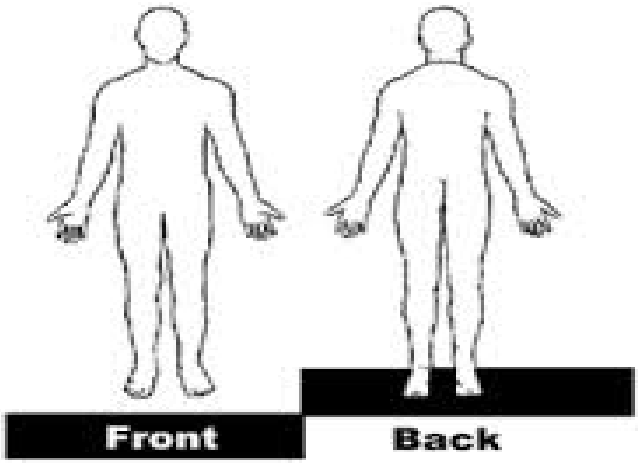
***What makes your pain better?*** _____

_____

***What makes your pain worse?*** _____

_____

***Please mark the location where you have pain /symptoms***




**What time(s) of day is pain worse; Morning Afternoon Evening Night**

**Medications taken for this? Yes No (**If yes please list below)

***How bad is the pain (or range of pain) on a 1-10 scale below***

| *Mild* | | | **Moderate** | | | ***Severe*** | | | ***Disabling*** | |
|---|---|---|---|---|---|---|---|---|---|---|
| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |

**Have you seen anyone else for this condition? Yes No** (If yes please list below)

**Have you had injuries to this area in the past? Yes No** (If yes please list below)

**Please list any activities of daily living that your current symptoms are affecting** (e.g. sleep, sitting, focus, work, standing, housework, etc.)

1. _____ 2. _____
3. _____ 4. _____

**SYSTEMS REVIEW QUESTIONS:**

Do you or have you ever had any problems with the following area? (Please check boxes to indicate problem areas)

| | | | |
|---|---|---|---|
| ☐ Eyes | ☐ Muscles | ☐ Allergies | ☐ Ears, Nose, Mouth, Throat |
| ☐ Nerves | ☐ Brain (Anxiety, Depression) | ☐ Heart | ☐ Joints/Bones |
| ☐ Lung/Breathing | ☐ Skin | ☐ Digestion/Intestines/Bowel | ☐ Metabolism / Internal Organs or disorders |
| ☐ Urinary | ☐ Blood | ☐ Prostate / reproductive | ☐ Gynecological/Menstrual/Breast |

Add additional comments or explanations on any above checked boxes _____

_____

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Recreational, exercise or outdoor activities _____

Work history: Type of work_____ Hours per week worked _____ Hours sitting _____ Standing _____

Do you follow any particular diet plan (Low fat, Mediterranean, etc.)? Yes No _____

Do you have any known or suspected food allergies or sensitivities? Yes No _____

Stress level on 1-10 (10=high) over last 3 months _____ Stressors _____

Sleep – □ Trouble falling asleep □ Trouble staying asleep □ Trouble waking up Sleep quality 1=poor 10=great _____

Do you get up during the night? Yes No Do you wake up during the night? Yes No Restless sleeper / restless legs Yes No

Are you stiff, tight, or have headaches commonly when you wake up? Yes No Do you have sleep apnea or snore? Yes No Unsure

Energy level overall 1-10 (10= good) _____ Do you wake up refreshed and energized? Yes No Do you need coffee in morning? Yes No

Height ____feet _____inches Weight _____ Have you gained weight since high school? Yes No Do you gain weight easily? Yes No

Please list medications you take (include over the counter and vitamins): _____

_____

_____

Have you had any other significant traumas? (Auto accidents, falls, etc....): _____

Family History: Please check box to all that apply to Mother (M), Father (F), Brother (B), Sister (S)

| Illness | Mother | Father | Brother | Sister | Grandparent |
|---|---|---|---|---|---|
| Autoimmune / Thyroid | | | | | |
| Cancer | | | | | |
| Heart / BP or circulation | | | | | |
| Arthritis | | | | | |
| Diabetes | | | | | |
| Depression | | | | | |
| Neurological disorders | | | | | |
| Other _____ | | | | | |

**I hereby authorize and give consent to Dr. Poquette and staff to evaluate and treat myself (or minor that I am a parent or guardian of);**

**Printed Name of patient (or minor)** _____ **Date** _____

**Signature of patient (or guardian if minor)** _____

Office / Dr. Use only