Nob Hill Chiropractic
201 Dartmouth Dr. SE
(505) 265-9656

MEDICAL AND HEALTH HISTORY

Date__________________ Patient Name______________________________ Date of Birth______________

Primary Complaint____

Other Dr. seen for this condition? ❑YES ❑NO WHO?________________________________

Results:____

What caused the pain?______________________________________ When did it start?______________

Is the condition Job Related Auto Related Home Injury Fall Other______________________

Circle the word or words that best describe the pain:

Aching Dull Sharp Shooting Bright Diffused lightening-like Throbbing Nagging

Deep Burning Stinging Pressure-like

How often does the pain occur? ❑Occasionally ❑Frequently ❑Constantly

Does the pain travel to any other areas? ❑YES ❑NO Where?______________________________

What makes the pain better?____

What makes the pain worse?____

Has this pain happened before? ❑YES ❑NO Explain:______________________________

Major Surgeries/Operations? ❑Appendectomy ❑Tonsillectomy ❑Gall Bladder ❑Hernia ❑Back Surgery ❑Broken Bones ❑Tumors ❑ Other:______________________

Major Accident(s) or Falls:____

Hospitalizations (other than above):____

Additional Complaints? ❑Allergies ❑Digestion ❑Headaches ❑Blood Pressure ❑Weight ❑Smoking ❑Alcohol ❑Other:______________________________

Please check the type of care desired so that we may help guide you: ❑Adjustments ❑Nutritional Counseling ❑X-Rays ❑Orthotics ❑Auricular Therapy ❑Food Allergies ❑Adrenal/Fatigue Test ❑Hormone Test ❑Neuro Emotional Technique ❑Bio-Energetic Synchronization Technique ❑Applied Kinesiology ❑Kinesio Tape

Have you had any of the following performed in the past for growth, healing, or development?

Body Work/Massage: ❑YES ❑NO ______________________________

Osteopathy: ❑YES ❑NO ______________________________

Homeopathy/Acupuncture: ❑YES ❑NO ______________________________

Yoga: ❑YES ❑NO ______________________________

Meditation: ❑YES ❑NO ______________________________

Psychotherapy: ❑YES ❑NO ______________________________

Exercise/Work Out: ❑YES ❑NO ______________________________

What, if any prescription drugs are you currently taking?______________________________

____

____

____

____

____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully. Please check off all that apply. A complete history and understanding of your health status will facilitate care. The first column for past conditions is for chronic issues. The second column for present conditions is for acute issues.

PAST	PRES	GENERAL SYMPTOMS
____	____	Headache
____	____	Fever
____	____	Chills
____	____	Night Sweats
____	____	Fainting
____	____	Dizziness
____	____	Convulsions
____	____	Loss of Sleep
____	____	Fatigue
____	____	Nervousness
____	____	Loss of Weight
____	____	Numbness or Pain in Arms/legs/hands
____	____	Allergy (what kind)
____	____	Wheezing
____	____	Neuralgia

PAST	PRES	GASTRO-INTESTINAL
____	____	Poor Appetite
____	____	Poor Digestion
____	____	Excessive Hunger
____	____	Belching or Gas
____	____	Nausea
____	____	Vomiting
____	____	Vomiting Blood
____	____	Pain Over Stomach
____	____	Constipation
____	____	Diarrhea
____	____	Colon Trouble
____	____	Hemorrhoids (Piles)
____	____	Liver Trouble
____	____	Jaundice
____	____	Gall Bladder Trouble

PAST	PRES	EYE/EAR, NOSE/THROAT
____	____	Poor Vision
____	____	Crossed Eyes
____	____	Pain in Eyes
____	____	Deafness
____	____	Earache
____	____	Ear Discharge
____	____	Nasal Obstruction
____	____	Nose Bleeds
____	____	Sore Throat
____	____	Hoarseness
____	____	Hay Fever
____	____	Asthma
____	____	Frequent Colds
____	____	Enlarged Thyroid
____	____	Tonsillitis
____	____	Sinus Trouble

PAST	PRES	MUSCLE & JOINT
____	____	Weakness
____	____	Twitching
____	____	Stiff Neck
____	____	Backache
____	____	Swollen Joints
____	____	Tremors
____	____	Foot Troubles
____	____	Painful Tail Bone
____	____	Pain Between Shoulders
____	____	Hernia
____	____	Spinal Curvature

PAST	PRES	FOR WOMEN ONLY
____	____	Painful Periods
____	____	Excessive Flow
____	____	Irregular Cycles
____	____	Hot Flashes
____	____	Cramps or Backache
____	____	Miscarriage

PAST	PRES	CARDIO-VASCULAR
____	____	Rapid Heart
____	____	Slow Heart
____	____	High Blood Pressure
____	____	Low Blood Pressure
____	____	Pain Over Heart
____	____	Previous Heart Trouble
____	____	Swelling of Ankles
____	____	Poor Circulation
____	____	Varicose Veins
____	____	Stroke(s)

PAST	PRES	GENTO-URINARY
____	____	Frequent Urination
____	____	Painful Urination
____	____	Blood in Urine
____	____	Kidney Infection
____	____	Bed Wetting
____	____	Inability to Control Urine
____	____	Prostate Trouble

PAST	PRES	SKIN ALLERGIES
____	____	Skin Euptions
____	____	Itching
____	____	Bruising Easily
____	____	Dryness
____	____	Boils
____	____	Sensitive Skin
____	____	Hives or Allergy
____	____	Eczema
____	____	Medicines Used

PAST	PRES	RESPIRATORY
____	____	Chronic Cough
____	____	Spitting Blood
____	____	Spitting Phlegm
____	____	Chest Pain
____	____	Difficulty Breathing

PAST	PRES	HABITS
____	____	Smoking ____pks/day____
____	____	Drinking ____Alcohol____
____	____	Coffee ____cups/day____

PAST	PRES	HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?	PAST	PRES	
____	____	Appendicitis	____	____	Goiter
____	____	Pneumonia	____	____	Influenza
____	____	Rheumatic Fever	____	____	Pleurisy
____	____	Polio	____	____	Alcoholism
____	____	Tuberculosis	____	____	Influenza
____	____	Whooping Cough	____	____	Arthritis
____	____	Anemia	____	____	Venereal Infection
____	____	Mumps	____	____	Epilepsy
____	____	Chicken Pox	____	____	Mental Disorder
____	____	Diabetes	____	____	Lumbago
____	____	Cancer	____	____	Eczema

FAMILY HISTORY	DIABETES	HEART	KIDNEY	CANCER	BACK
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Sister (# of_____)	☐	☐	☐	☐	☐
Brother (#of_____)	☐	☐	☐	☐	☐

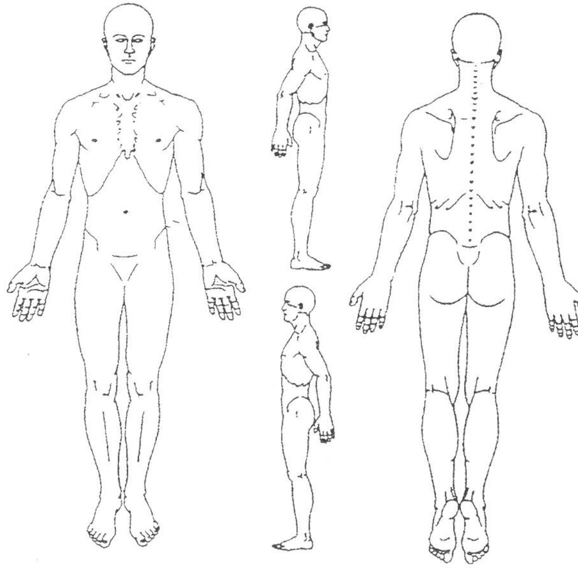
General Pain Disability Index Questionnare

Name (please print) ______________________ Date ______________

Circle areas of discomfort & use letters below to indicate type & location of current pain

A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing I = Intense

O = Other (describe)



Pain Questionnaire

1. **Family/Home Responsibilities:** includes chores and duties around home (e.g. yard work) and errands for other family members (e.g. driving children to school).

   1 2 3 4 5 6 7 8 9

   completely able to function — totally unable to function

2. **Recreation:** includes hobbies, sports, other similar leisure time activities.

   1 2 3 4 5 6 7 8 9

   completely able to function — totally unable to function

3. **Social:** acitivities with friends such as parties, theatre, dining out and other social functions

   1 2 3 4 5 6 7 8 9

   completely able to function — totally unable to function

4. **Occupation:** activities directly related to job (includes non-paying such as home-making and volunteer work).

   1 2 3 4 5 6 7 8 9

   completely able to function — totally unable to function

5. **Self Care:** includes activities which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dresses, etc.).

   1 2 3 4 5 6 7 8 9

   completely able to function — totally unable to function

6. **Life-Support:** includes activities such as eating, sleeping, and breathing.

   1 2 3 4 5 6 7 8 9

   completely able to function — totally unable to function