



PATIENT HISTORY FORM

Name _____ Date ____/____/____

Occupation _____ Date of Birth ____/____/____

CHIEF COMPLAINT

Exact Description _____

Related to: Fall Accident Onset Date ____/____/____ Recurrence Progress: Worse Same Better

PREVIOUS MEDICAL CARE FOR CHIEF COMPLAINT

Name and Location of Doctor _____

Date Attended ____/____/____ Hospital _____

Examinations and X-Rays Made _____

Condition or Diagnosis _____

Type of Treatment _____

Duration of Treatment _____

Results of Treatment Good Fair Poor Previous Chiropractic Care Yes No

SECONDARY COMPLAINT

Condition _____

Onset _____ Becoming Worse Same Better

Name of Doctor _____ Date of Care ____/____/____

Results of Treatment Good Fair Poor _____

OTHER COMPLAINTS

Condition _____

Onset _____ Becoming Worse Same Better

Name of Doctor _____ Date of Care ____/____/____

Results of Treatment Good Fair Poor _____

PAST HISTORY

Recent Surgery _____

Present or Recent Treatment for other Condition _____

Previous Serious Illness _____

Date of Last Physical Examination ____/____/____ Doctor _____

What prompted Physical Examination _____

Results of Examination _____

Present Family Doctor _____