Pappas Chiropractic, D.C., P.C.

Personal and Family Health History Date______/______/________

Name____
Please Print First Middle Initial Last

Address____

City__________________________ State_______ Zip___________

Phone (H)____

(W)_______________________(C) _________________________

E-mail____

Date of Birth________/_______/___________ Age_____________

Social Security #___________-____________-________________

Marital Status S M D W

Occupation____

Employer____

Name of Primary insurance____

Spouse/Parent Name____

Spouse/Parent Employer____

Spouse/Parent SS#_________-________-____________DOB____/____/____

Name of Secondary Insurance______________________________________

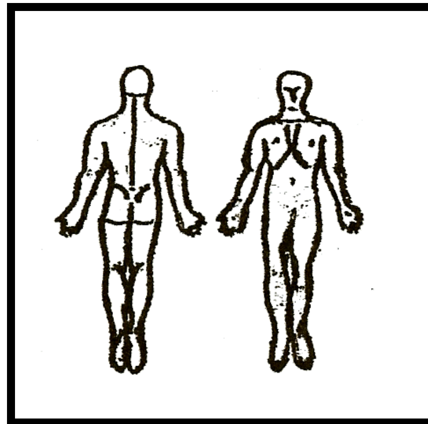
Emergency Contact Name____

Emergency Contact #____

Referred By: ____

Current Health Habits	Patient
Smoke?	
Drink? (alcoholic beverages)	
Diet? (eat healthy foods)	
Been in accidents?	
Had organs replaced/removed?	
Drugs? Rx or non Rx	
Have teeth problems?	
Have eye problems?	
Have hearing problems?	
Exercise regularly?	
Have sleeping problems?	
Have occupational stress?	
Have physical stress?	
Have mental stress?	

Growth & Development, did you ever once….	Patient
Learn to care for your spine?	
Have any accidents?	
Have sports injury?	
Have surgery?	
Take drugs?	
Experience other traumas?	



Mark an X on affected areas

VITAMINS:

____

____

MEDICATIONS:

____

____

Sleeping posture? (Circle one) side stomach back

Are you **pregnant**? Y N

Have you seen a Chiropractor before? Y N

___________________ Last visit date____________________ Previous issue____________________

Do you have a **pacemaker**? Y N

Have you ever had any **surgeries**? Y N

What and when?

____

____

Current Health Condition

Reason for Your Visit Today
Major ____

Pain or Problem started ____

Pains are: ❐ **Sharp** ❐ **Dull** ❐ **Constant** ❐ **Intermittent**

What activities aggravate your condition/pain? ____

What activities lessen your condition/pain? ____

Is condition worse during certain times of the day? ____

Is this condition interfering with work? ___________ Sleep? __________ Routine? __________ Other? ________________________

Is this condition getting progressively worse? ____

Other doctors seen for this condition? ____

Any home remedies? ____

Accident Information

Is condition due to an accident? Y N Date ______________________

Type of accident ❐ Auto ❐ Work ❐ Home ❐ Other

To whom have you made a report of your accident? ❐ Auto Insurance ❐ Employer ❐ Worker Comp ❐Other

Attorney Name (if applicable) ___________________

Other symptoms:

❐ Headaches	❐ Face Flushed	❐ Stiff Neck	❐ Cold Hands
❐ Dizziness	❐ Fever	❐ Chest Pains	❐ Cold Feet
❐ Light Bothers Eyes	❐ Fainting	❐ Shortness of Breath	❐ Numbness in Fingers
❐ Loss of Memory	❐ Cold Sweats	❐ Back Pain	❐ Numbness in Toes
❐ Loss of Taste	❐ Depression	❐ Sleeping Problem	❐ Pins & Needles in Arms
❐ Loss of Smell	❐ Nervousness	❐ Stomach Upset	❐ Pins & Needles in Legs
❐ Loss of Balance	❐ Fatigue	❐ Constipation	❐ Other ______________
❐ Buzzing in Ear	❐ Tension	❐ Diarrhea	
❐ Ringing in Ear	❐ Neck Pain	❐ Irritability	

Family Health History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _______________
Father's Side	❐	❐	❐	❐	❐
Mother's Side	❐	❐	❐	❐	❐

Primary Doctor Communication

We strive to provide the best care possible and routinely communicate with primary care doctors to keep them up to date on what is happening with their patients. We would like your permission to communicate with your primary care doctor about the care that you are receiving here.

❐ Please check the box if you would like us to send case notes to your primary care doctor
Primary provider name:______________________________
Primary provider number:____________________________

____
Patient/Guardian Signature