LOCK CENTER CHIROPRACTIC
HEALTH AND HISTORY ASSESSMENT

NAME:_____ DATE:_____ ACCT #_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE:_____ WORK PHONE:_____ E-MAIL ADDRESS:_____

HEIGHT:_____ WEIGHT:_____ BIRTHDATE:_____ MARTIAL STATUS:_____

SOCIAL SECURITY #:_____ EMPLOYER:_____

DO YOU HAVE INSURANCE? ☐ YES, ☐ NO - INUSRANCE COMPANY:_____

OCCUPATION:_____ REFERRED BY:_____

SUMMARY OF JOB TASKS:_____

_____

1. Please list your present symptoms:_____
   _____
   _____

2. If multiple symptoms, which one is your MAIN concern?_____
   _____
   _____

3. When did you first notice this problem?_____
   _____
   _____

4. Was it caused by: ☐ Auto Accident ☐ On the Job Injury ☐ Other_____
   Describe:_____

5. Have you been treated for this condition? ☐ YES ☐ NO - If yes, when?_____
   By Whom:_____Results:_____
   _____

6. Have you been treated by a chiropractor? ☐ YES ☐ NO - If yes, when?_____
   Results and Impressions:_____
   _____

7. Activities of daily living that increase or decrease symptoms (i.e., Sitting, Standing, Walking, Bending):
   _____
   _____

8. List activities that you would like to do but can't because of your symptoms:_____
   _____
   _____

9. List all previous illnesses, injuries and hospitalizations/operations (please include any plastic/ augmentations surgeries performed, area of body) symptoms, date, include medications:_____

_____

_____

10. Are you currently being treated by another doctor? ☐ YES ☐ NO - If yes, by whom:_____

_____

Why:_____

11. Are you currently taking any over the counter or prescription medications? ☐ YES ☐ NO - If yes, What & Why?_____

12. **SYSTEM REVIEW** (please check those symptoms or conditions you have now or have had), please indicate with a **C** the symptoms you hare having now:

_____ Constipation	_____ Ear Disorder	_____Stroke	_____Skin Problems
_____ Diarrhea	_____ Emphysema	_____Cold Feet & Hands	_____Worms
_____ Colitis	_____ Asthma	_____Kidney Stones	_____Liver Trouble
_____ Heartburn	_____ Allergies	_____Nervous Stomach	_____Frequent Sore Throat
_____Gas	_____ Chest Pain	_____Blood in Stool	_____Irregular Heartbeat
_____ Vomiting	_____ Colon Trouble	_____Spiting Up Blood	_____Bed Wetting
_____ High/Low BP	_____ Blood in Urine	_____Hiatal Hernia	_____Arthritis
_____ Chronic Cough	_____ Kidney Infection	_____Bladder Infection	_____Gall Bladder
_____ Hemorrhoids	_____ Pain in Ribs	_____Nausea	_____Sexual Dysfunction
_____Color of Stool (☐ Black ☐ Brown ☐ White ☐ Tan)		_____ Other_____	

WOMAN ONLY

_____ Hot Flashes	_____ Irregular Period	_____Excessive Flow	_____Lumps in Breast
_____ PMS	_____ Menopause	_____Pregnant	_____Menstrual Cramps

_____ Other _____

MEN ONLY

_____ Prostate Trouble _____ Difficulty with Urination _____Other_____

13. **FAMILY HISTORY** please check those diseases that have affected you or your family:

_____ Heart Disease	_____ Epilepsy	_____Asthma	_____Sinus Problems
_____ Tuberculosis	_____ Anemia	_____Retardation	_____Cancer
_____ Diabetes	_____ HIV Positive	_____Psychiatric	_____Kidney Disease
_____ High B/P	_____ Overweight/Obesity	_____Anorexia/Bulimia	_____Circulatory Problems

_____Other_____

14. **SOCIAL HISTORY:**

Do you smoke? ☐ YES ☐ NO - If yes, indicate number of packs per day:_____
Do you exercise? ☐ YES ☐ NO - If yes, describe:_____
Do you drink coffee? ☐ YES ☐ NO - Describe regularity:_____
Do you drink tea? ☐ YES ☐ NO - Describe regularity:_____
Do you drink alcoholic beverages? ☐ YES ☐ NO - Describe regularity:_____
Are you on any special diet? ☐ YES ☐ NO - Describe:_____

_____

THANK YOU for completing this questionnaire. This information is necessary for the doctor in evaluating your condition.
I authorize the release of any information required and that my benefit payments be paid directly to this clinic.
Please sign below that the information you have provided is true and correct.

PAYMENT WILL BE MADE BY: ☐ CASH ☐ CHECK ☐ CREDIT CARD (ALL MAJOR CARDS ACCEPTED). I acknowledge that payment is due upon service being rendered to me.

_____ _____

Print Patient or Guardian's Name **Witness**

_____ _____

Patient or Guardian's Signature **Date**