EPC
ELITE PERFORMANCE
CHIROPRACTIC

Patient History Form

Name ______________________ Age _________ Date ________________
Address__________________________ City_______________ State ______ Zip _________
Home phone ____________________ Work# ________________________ Cell# ________________
Date of Birth ______________ Soc Sec# _____________________ Sex: M F Marital Staus: S M D W
Height _____________________ Weight ________________
Employer ___________________________________ Occupation ___________________________________
Email (optional) ____
Referred by anyone? ____
If Insured under another person: Name _________________________________ Relation: ________________
Insured's Date of Birth: ____________ __ Employer ____
In case of an Emergency: Name ______________________ Relation ________________ # ________________

Present condition due to an injury/accident? Yes_____ No_____ / On the Job_____ Auto Accident________
Other____
Has the accident been reported? Yes___ No___ To Employer___ Auto Insurance___ Other___________________

Health Report

Reason for seeking care ____
List any other Doctors seen for this condition ____
List any diagnosis and type of treatment ____
Have you had similar injuries or accidents before? Yes___ No___ If Yes, please explain:______________________
List names of relatives that have or have had a similar problem: _________________________________
Have you received chiropractic treatment before?_______ If yes, explain:_____________________________
Any recent X-Rays / MRI?____
Have you been treated by a physician for any health conditions within the last year? Yes___ No___
If yes, please explain: ____
Please list any medications you are currently taking: ____
List conditions you are taking medications for: ____
Do you take Vitamins/Supplements? Yes___ No___ / What kind/s and how often? ___________________________
Do you smoke? Yes___ No___ / Caffeinated Drinks per day______
Drink Alcohol? Yes___ No___ / Daily____ Weekly____ Social Occasions_________

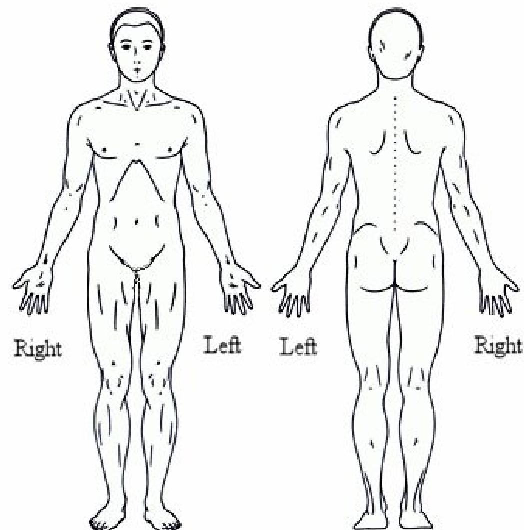
Family Health History

List any Health conditions / age of death and cause of death if deceased:
Father: ____
Mother: ____
Brother/s & Sister/s: ____

Please circle degree of pain. 0 none. 10 severe pain

0 1 2 3 4 5 6 7 8 9 10

Mark on the diagram to the right, where you feel pain
Numbness = = =
Dull Ache OOO
Burning XXX
Sharp/Stabbing ///////
Other ^^^^
What activities aggravate your pain?_________________
What activities lessen your condition/pain?_____________
Is this condition worse at certain times of the day? Y N
Is it interferring with: Work?________ Sleep? _________
Routine? ________ Other? __________________________
Is this condition progressivley getting worse?___________



Please mark each item below for each sign or symptom you presently have or previously had:

P = past **C = current**

GENERAL SYMPTOMS:	EAR/ NOSE/ THROAT:	RESPIRATORY:
__ Convulsions	__ Earache	__ Asthma
__ Dizziness	__ Ear Noises	__ Chronic Cough
__ Fainting	__ Enlarged Thyroid	__ Difficulty Breathing
__ Headache	__ Frequent Colds	__ Spitting Blood
__ Nervousness	__ Hay Fever	__ Spitting Phlegm
__ Numbness	__ Nasal Blockage	
__ Wheezing	__ Nose Bleeds	**GENITO-URINARY:**
	__ Pain Behind Eyes	__ Blood in Urine
MUSCLES & JOINTS:	__ Poor Vision	__ Frequent Urination
__ Low Back Problems	__ Sinusitus	__ Kidney Infection
__ Pain between Shoulders	__ Sore Throats	__ Painful Urination
__ Neck Problems	__ Tonsillitis	__ Prostate Problems
__ Arm Problems		__ Loss of Bladder Control
__ Leg Problems	**GASTRO-INTESTINAL:**	__ Kidney Stones
__ Swollen Joints	__ Belching / Gas	
__ Painful Joints	__ Colon Problems	**SKIN OR ALLERGIES:**
__ Stiff Joints	__ Constipation	__ Boils
__ Sore Muscles	__ Diarrhea	__ Bruising Easily
__ Weak Muscles	__ Excessive Hunger	__ Dryness
__ Walking Problems	__ Excessive Thirst	__ Eczema / Rash / Dermatitus
__ Sprains / Strains	__ Gall Bladder Trouble	__ Hives
__ Broken Bones	__ Hemorrhoids	__ Itching
	__ Liver / Gallbladder	__ Sensitive Skin
CARDIO-VASCULAR:	__ Nausea	__ Allergy __________________
__ High Blood Pressure	__ Abdominal Pain	
__ Heart Attack	__ Ulcer	**FOR WOMEN ONLY:**
__ Pain over Heart	__ Poor Appetite	__ Birth Control _____________
__ Poor Circulation	__ Poor Digestion	__ Hormone Replacement
__ Heart Trouble	__ Vomiting	__ Cramps / Backaches
__ Rapid Heart	__ Vomiting Blood	__ Excessive Flow
__ Slow Heart	__ Black Stool	__ Hot Flashes
__ Strokes	__ Bloody Stool	__ Irregular Cycle
__ Swelling Ankles	__ Weight Loss / Gain	__ Miscarriage
__ Varicose Veins		__ Painful Periods
		__ Vaginal Discharge
		__ Breast Pain
		Pregnant at this time? Y N

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient Signature:____ Date:_______________