LATIMER CHIROPRACTIC /PAMELA G. LATIMER D.C.

PATIENT HEALTH HISTORY

PLEASE ANSWER ALL QUESTIONS FULLY TO HELP THIS OFFICE SERVE YOU BETTER

NAME_____**CELL#**_____**Home #**_____
MAILING _____**STREET**_____
CITY_____STATE_____ZIP_____
SS#_____**DATE of Birth** _____**AGE**_____
OCCUPATION_____**COMPANY**_____
If retired, what did you do? _____**WORK#**_____
E-MAIL (for office communication)_____

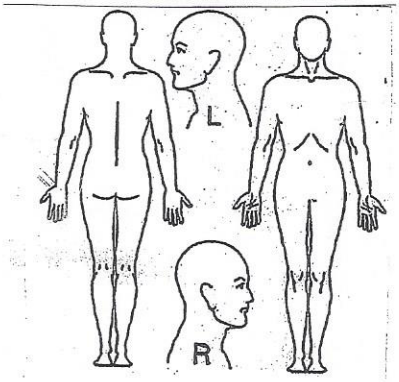
MARTIAL STATUS S M W Sep SPOUSE NAME_____
SPOUSE OCCUP_____ NAME OF COMPANY_____
CHILDREN_____AGES_____ EMERGENCY CONTACT_____ _____PH #_____

WHO CAN WE **THANK FOR REFERRING YOU TO THIS OFFICE?** _____
LOCAL DOCTOR's Name (Group name)? _____**LAST EXAM DATE**_____
HEALTH TREATMENTS (what) IN THE LAST YEAR? _____
_____

WHAT CAN WE HELP YOU WITH? _____
DESCRIBE WHAT YOU ARE FEELING BY

Using the symbols below:
Numbness xxxxxx
Pins & needles .....
Burning 0000000
Aching ^^^^^^^
Stabbing //////////

MARKING THE INVOLVED BODY PARTS



Less pain **Most**
1----------10
MARK THE RANGE OF PAIN YOU ARE IN

HOW AND WHEN DID IT ---**FIRST DEVELOP?** _____

What AGGRAVATES the problem? Sitting Standing Lifting Bed Walking Stairs Driving Reaching Carrying Twisting Squatting Other_____

HOW IS YOUR LIFE AFFECTED BY THIS PAIN?
Sitting limited Standing limited turn in bed more rest more other_____

WHAT RELIEVES the problem?
Meds (for pain) **Ice----------Heat** Not tried anything
_____ Movement/walking Sitting
Other_____

Usual **MEDICATIONS** YOU TAKE? purpose **?**_____
_____

VITAMINS YOU TAKE _____

Do you exercise and how often?_____

TREATMENTS FOR THIS IN THE PAST? **YES/NO _ BY WHOM** _____**RESULTS**_____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "**NONE**

Constitutional: NONE
- ☐ Chills/ Hot/Fever
- ☐ Daytime Drowsiness/ Fainting
- ☐ Weight Gain/Loss

Eyes/Vision: NONE
- ☐ Any issues_____

Ears, Nose, and Throat: NONE
- ☐ Dizziness/Ears/Pain/hearing
- ☐ Tinnitus (ringing in the ears)
- ☐ Headaches/Head Injury –history
- ☐ Nose/sinus symptoms
  Throat sore/hoarse/swallowing
- ☐ TMJ Disorder/pain/click

Respiration: NONE
- ☐ Breathing Issues

Cardiovascular: NONE
- ☐ Heart Problems
- ☐ Chest Pain
- ☐ Arm/leg pain or achiness/swelling
- ☐ Ulcers/Varicose Veins

Gastrointestinal: NONE
- ☐ Bowels/cramp/bleed/loose
- ☐ Appetite Changes/ Vomiting
- ☐ Heartburn/Indigestion/Nausea

Endocrine NONE
- ☐ Diabetes/Blood Sugar Problems
- ☐ Excessive Thirst/ Hunger
- ☐ Frequent Urination
- ☐ Hair Loss/ Growth
- ☐ Heat/ Cold Intolerance
- ☐ Voice Changes/ Lymph Node Swelling

Female/ Male: NONE
- ☐ Birth Control Therapy
- ☐ Breast Symptoms
- ☐ Urination Symptoms
- ☐ Hormone Therapy
- ☐ Menstruation Symptoms
- ☐ Vaginal/Penis Symptoms
- ☐ Prostate Symptoms

Skin: NONE
- ☐ Changes in skin color/texture
- ☐ Itching/ Rash/ Hives
- ☐ (numb/heat/tingling)
- ☐ History of Skin Disorders

Nervous System/ Psych: NONE
- ☐ Dizziness/ Headaches/Facial Weak/ Speech Symptoms
- ☐ Limb Weak/ Numb/ Tremors/Loss of Consciousness
- ☐ Loss of Memory/ Seizures/ Strokes
- ☐ Sleep Symptoms/ Insomnia
- ☐ Walking Issues
- ☐ Anxiety/Depression/Confusion/Behavioral Change(s)
- ☐ Bipolar/Depression/Mood Change(s)

Allergy: NONE
- ☐ Food Intolerance
- ☐ Itching/rash
- ☐ Nasal Congestion/ Sneezing
- ☐ Allergies

Hematology: NONE
- ☐ Anemia
- ☐ Bleeding/Clotting/Bruises Easily

PLEASE circle ALL THAT APPLY OVER YOUR entire life & General Dates

AUTO ACCIDENTS _____SURGERIES_____

TRAUMA/FALLS _____

BROKEN BONES _____CONTACT SPORTS _____

ALCOHOL use _____HEAVY LIFTING JOBS _____

DO YOU WEAR A SEAT BELT REGULARLY? Yes ___ No ___ Sometimes _____

I give permission for the doctor to examine me and do all tests necessary, for my treatment at Latimer Chiropractic Total Wellness Center

PATIENT SIGNATURE _____**DATE**_____

If minor NAME OF PARENT/GUARDIAN _____**PHONE (cell-OR-home)** _____

I hereby authorize Pamela G. Latimer, D.C. and whomever she may designate to administer care as is deemed necessary to my son/daughter/ward.

PARENTS SIGNATURE_____DATE_____ _WITNESSED _____