WENGER CHIROPRACTIC GROUP
MEDICAL HISTORY

Today's Date:_____
Computer#:_____

Name:_____
Email:_____ Date of Birth:_____ Height:_____ Weight:_____

What is the primary reason/problem/condition you have come in for chiropractic treatment?

_____

_____

Have you had similar problems before? ☐No ☐Yes If yes, When?_____

Have you had Chiropractic care in the past? ☐No ☐Yes

Are there any other issues/problems you wish the doctor to know about: _____

_____

Have you had any recent falls, traumas or other accidents? ☐No ☐Yes Describe:_____

_____

What is the initial date of injury or onset of this condition? _____ Are you off from work? ☐No ☐Yes

Rate your restriction of performing activities of daily living on a scale from 0 to 10

(no restriction) 0 1 2 3 4 5 6 7 8 9 10 (severe restriction)

Over the past 2 weeks what is your average level of pain on a scale from 0 to 10?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain) What level is your pain today? ____/10

Is your pain or discomfort? (Mark with a ✓) ☐continuous ☐off and on ☐getting worse ☐ sharp or stabbing

Do you perform moderately intense exercise 3 time per week? ☐No ☐Yes

Is your MD currently co-treating your condition? ☐No ☐Yes If yes, who: _____

What recent diagnostic studies (x-ray, MRI, CT, blood work) have you had? _____

Taken where? _____

List symptoms you have had recently: ☐Headache ☐Numbness or tingling in arms/hand or legs/feet ☐Fever

[ ] Difficulty sleeping Other:_____

List your Current Medications:_____

Medication Allergies:_____

List your Allergies: ☐None ☐Seasonal/Pollen ☐Food ☐Animals ☐X-Ray Dye ☐ Other:_____

List any Surgeries: ☐None ☐Neck ☐Back ☐Hip ☐Knee ☐Shoulder ☐Brain ☐Other:_____

_____

List your Medical Conditions: ☐None ☐High Blood Pressure ☐Diabetes ☐Stroke ☐Cancer

☐Other:_____

List your Family Medical History (Example: maternal grandmother - high blood pressure, Father – heart attack)

_____

Do you smoke or use tobacco products? ☐No ☐Yes Former Smoker? ☐No ☐Yes
Do you have currently have significant problems with depression or anxiety? ☐No ☐Yes

Do you drink alcohol? ☐No ☐Yes – How many per day? _____
Do you drink caffeine? ☐No ☐Yes – How many per day? _____
Do you exercise? ☐No ☐Yes – What forms and how often?_____

Patient Signature:_____ Date:_____