Hometown Wellness & Chiropractic Center, LLC
120 East State Street, Suite 100 Media, PA 19063

DATE_____

CONFIDENTIAL HEALTH HISTORY

PATIENT NAME_____ DATE OF BIRTH_____

ADDRESS_____ CITY_____ STATE_____

PRIMARY PHONE_____ SECONDARY PHONE_____

EMAIL ADDRESS_____

OCCUPATION_____ EMPLOYER/SCHOOL_____

REFERRED TO OUR OFFICE BY_____

CURRENT HEALTH CONDITION

PRIMARY COMPLAINT_____

_____

HOW DID THIS CONDITION DEVELOP? (please circle)

OVEREXERTION STRENUOUS POSITION

AUTO ACCIDENT WORK ACCIDENT

TRIP/FALL OTHER

WAS THERE A SPECIFIC CAUSE?

_____

WHEN DID THE PROBLEM BEGIN?

(Date)_____

DESCRIBE YOUR PAIN SYMPTOMS (please circle)

DULL ACHE SHARP STABBING

THROBBING OTHER_____

HOW OFTEN DO YOU FEEL PAIN? (please circle)

INTERMITTENT OCCASIONAL FREQUENT

CONSTANT OTHER_____

WHAT MAKES THE PROBLEM WORSE? (please circle)

PROLONGED SITTING BENDING COUGHING

PROLONGED STANDING DRIVING

SNEEZING LIFTING SLEEPING EXERCISE

OTHER_____

WHAT RELIEVES THE PROBLEM? (please circle)

REST EXERCISE SITTING STANDING

LYING OTHER_____

DOES PAIN TRAVEL TO YOUR? (please circle)

ARMS HANDS LEGS FEET(RIGHT/LEFT)

HAVE YOU HAD SIMILAR PAIN BEFORE? (YES/NO) EXPLAIN _____

_____

HAVE YOU RECEIVED TREATMENT FOR THIS ISSUE IN THE PAST? (YES/NO)

IF YES, BY WHOM/WHEN?_____

PAST HEALTH HISTORY

GENERAL HEALTH: (please circle) EXCELLENT GOOD FAIR POOR Explain_____

SURGERY_____

MAJOR ACCIDENTS/ FALLS_____ BROKEN BONES_____

ALCOHOL USE_____ TOBACCO USE_____

ALLERGIES_____

PRESCRIPTION USE_____

ANY HOSPITALIZATION DATES_____

REASON_____

EXERCISE: FREQUENCY_____ TYPE_____

ANY DIFFICULTIES WHILE EXERCISING_____

DIET: (please circle) EXCELLENT GOOD FAIR POOR Explain_____

FAMILY HISTORY: (please circle)

HIGH BLOOD PRESSURE DIABETES HEART ATTACK STROKE CANCER OSTEOPOROSIS