Dr. Grace E. Lohr

CONFIDENTIAL HEALTH HISTORY

Patient Information

Thank you for choosing our practice for your chiropractic needs.
If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Date: _____ E-mail Address: _____

Name (First): _____ MI: _____ (Last): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

Birthdate: _____ Age: _____ Height: _____ Weight: _____ Social Security #: _____

Are you? □Male □Female □Married □Single □Widowed □Divorced □Separated

Do you have children? □Yes □No Ages: _____

Your Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse's or Parent's Name: _____ Workplace: _____ Work Phone: _____

Whom may we notify in an emergency? Name: _____ Phone: _____ Relationship: _____

Symptoms

Reason for visit: _____

When did your problem begin? _____

Did it begin: □Gradual □Sudden □Progression over time

Have you experienced a similar problem before? _____

Did it start from an injury? □Yes □No What happened? _____

Is this condition getting: □Better □Worse □Staying the same

Which activities are difficult to perform? □Sitting □Standing □Walking □Bending □Lying Down

□Other: _____

Type of Pain: □Sharp □Dull □Numbness □Stiffness □Aching □Throbbing □Shooting □Burning □Tingling □Cramps

Rate the severity of your pain (1-mild pain or discomfort to 10-severe pain):

1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What makes it better? _____

What makes it worse? _____

What treatment have you already received for your condition? _____

□Medication □Surgery □Physical Therapy □Other _____

Name and address of other practitioner(s) who have treated you for your condition:

_____

_____

Health History

Check conditions that apply:

□Aids/HIV	□Fracture/Broken Bone	□Migraine Headaches	□Stroke
□Alcoholism	□Gout	□Multiple Sclerosis	□Thyroid Problems.
□Anemia	□Heart Disease	□Osteoporosis	□Ulcers
□Arthritis	□Hepatitis	□Pacemaker	□Varicose Veins
□Asthma	□Hernia	□Parkinson's Disease	□Vision Problems
□Cancer	□Herniated Disc	□Polio	□Other:_____
□Depression	□High Blood Pressure	□Psychiatric Care	_____
□Diabetes	□Menstrual Cramps	□Sinus	_____

Date of last medical exam?_____

(Women) Are you pregnant? □Yes □No Nursing? □Yes □No
Taking birth control pills? □Yes □No

List any surgeries you have had and any times you have been hospitalized (include dates):

_____

_____

Please list all medications that you are currently taking and the reasons:

_____

_____

Have you ever been seen by a chiropractor before? □Yes □No When?_____

For what condition? _____

Family History

Does anyone in your family have a condition similar to yours? □Yes □No Who?_____

Does anyone in your family have?

□Arthritis	□Back Pain	□Cancer	□Diabetes	□Disc Disorders
□Headaches	□Heart Disease	□High Blood Pressure	□Migraine Headaches	

Daily Habits

What type of exercise do you perform on a daily basis? □None □Moderate □Heavy

What do your daily work habits include (i.e. standing, sitting, light labor, heavy labor, computer work):

_____

_____

What vitamins do you currently take?_____

What kind of other nutritional supplements do you take (if any)?_____

Do you smoke? □Yes □No

How much alcohol do you consume on a weekly basis?_____

How much coffee or caffeinated beverages do you consume on a daily basis?_____

Authorization

I certify that I have read and understand and answered the above information to the best of my knowledge. I authorize Dr. Lohr to perform a chiropractic evaluation and, if appropriate, treatments for my condition.

X_____

Signature of Patient (or parent if a minor) Date