Dr McMakin's Chiropractic FSM Clinic

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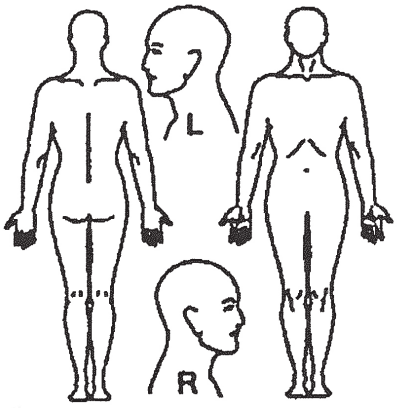
Chiropractic Physician • Diagnosis + Treatment of Chronic Pain • Frequency Specific Microcurrent

MEDICAL HISTORY

Patient name: _____ Date: _____

Please fill out this form as accurately as possible. It greatly helps the doctor in providing the appropriate care tailored to your needs. When something does not apply write N/A.



1. On the diagram at the right, please circle the areas where you are experiencing your symptoms.

2. When did you first notice this problem? (Check one):
☐ Originally ☐ Most Recently. Is it getting: ☐ better ☐ worse?

3. Are your symptoms: ☐ constant ☐ intermittent?

4. Please describe the quality of your pain. (Check all that apply):
☐ sharp ☐ dull ☐ tingling ☐ achy ☐ numb ☐ stabbing ☐ burning

5. Does it seem to spread to another area? (Circle all that apply):
☐ neck ☐ mid-back ☐ low back ☐ arms ☐ legs ☐ shoulder ☐ head ☐ other: _____

6. Please make a mark on the line which corresponds to how you presently feel.

NO PAIN		WORST PAIN

7. What makes your pain better? (Check all that apply):
☐ sitting ☐ lying ☐ standing ☐ massage ☐ ice ☐ heat ☐ medication ☐ other: _____

8. What makes your pain worse? (Check all that apply):
☐ movement ☐ sitting ☐ lying ☐ standing ☐ heat ☐ coughing/sneezing ☐ stress ☐ bowel movement
☐ lifting ☐ other: _____

9. Are you having any symptoms that you associate with this pain? (Check all that apply):
☐ headaches ☐ vision problems ☐ coughing ☐ sneezing ☐ trouble swallowing ☐ ear symptoms
☐ digestion problems ☐ difficulty breathing ☐ weight loss ☐ chills/fever ☐ problem with urination
☐ bowel movement ☐ nausea ☐ dizziness ☐ other: _____

10. Please describe what you believe to be the cause of your symptoms. Was your condition caused by an:
☐ Auto Accident ☐ On the Job Injury ☐ Other: _____

11. Have you had any previous treatment for this condition? (Check One) ☐ Yes ☐ No
When?_____ Who treated you? _____
For how long?_____ Results? _____

12. Please give us the names of any chiropractors you have treated with in the past and how long since your last treatment. _____

Form submitted by: ☐ Dr Carolyn McMakin ☐ Dr Sandra Osterberg

1. Are you now, or have you suffered from the following? Please check **Past, Present,** or **No** in the boxes.

PAST	PRESENT	NO		
			Arteriosclerosis	
			Asthma	
			Arthritis	
			Cancer	
			Diabetes	
			Dizziness / Fainting	
			Anemia	
			HIV Infection	
			Tuberculosis	
			Measles	
			Appendicitis	
			Carpal Tunnel	
			Scarlet Fever	
			Kidney Disease	
			Eczema	
			Chicken Pox	
			Double or Blurred Vision	
			Epilepsy	
			Heart Attack / Disease	
			High Blood Pressure	
			Migraines	
			Back Surgery	
			Pleurisy	

PAST	PRESENT	NO		
			Digestive Disorders	
			Mumps	
			Thyroid Problems	
			Venereal Disease	
			Hepatitis	
			Depression	
			Broken Bones	
			Multiple Sclerosis	
			Polio	
			Stroke	
			Ear Infection	
			Rheumatic Fever	
			Allergies	
			Influenza	
			Fatigue (Chronic)	
			Sinus Trouble	
			Pneumonia	
			TMJ	
			Low Blood Pressure	
			Ulcer	
			Drug or Alcohol Dependence	
			Gout	
			Other	

2. Does anyone in your immediate family have, or have had:
☐ Heart Disease ☐ Tuberculosis ☐ Cancer ☐ Cystic Fibrosis ☐ Stroke ☐ High Blood Pressure
☐ Gout ☐ Blood Diseases ☐ Other: _____

3. Do you smoke or use tobacco products? ☐ No ☐ Yes If yes, how much? _____

4. Do you drink alcoholic beverages? ☐ No ☐ Yes If yes, how often? _____

5. Do you drink caffeinated beverages? ☐ No ☐ Yes If yes, how often? _____

6. Please list any accidents, injuries, or hospitalizations and when they occurred: _____

7. Please list any surgeries and when: _____

_____

8. Please list all medications, including birth control pills, aspirin, cortizone, or vitamins you are currently taking:

_____

9. Are you currently under a doctor's care? ☐ No ☐ Yes If yes, who and why? _____

10. Which of the following describes your treatment goals in this office:
☐ Pain Relief ☐ Corrections of Problem ☐ Rehabilitation ☐ Need More Information _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient printed name: _____

Patient Signature: _____ Date: _____