Integrity Chiropractic | 610 Market Street Suite 103, Kirkland, WA 98033 | 425-298-0665

DEMOGRAPHIC & MEDICAL HISTORY FORM

(FORM UPDATED 05/02/19)

Patient Name: _____ Date of Birth: _____Today's Date: _____

Address: _____

Phone #: _____ Email: _____ Occupation: _____

Emergency Contact Name & Phone #: _____

How Did You Hear About Us? _____

PATIENT MEDICAL HISTORY

We will discuss the reason for your visit in the interview. PLEASE INDICATE ANY MEDICAL CONDITIONS OR PROBLEMS AS THEY MAY AFFECT YOUR TREATMENT. We will have you update this form on a yearly basis. Please use update any changes in your medical history at that time.

☐ **Existing Patients: Check here for no changes in medical history in the past year. If there are, simply note the changes. We keep this in your file.**

General

- ☐ Recent weight gain; how much _____
- ☐ Recent weight loss; how much _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

Musculoskeletal

- ☐ Bone Disease / Cancer of Bone
- ☐ Neck / Back / Spine Problems
- ☐ Sprain/Strains
- ☐ Tendonitis / Bursitis
- ☐ Fibromyalgia
- ☐ Jaw Pain (TMJ)
- ☐ Recent (1 yr.) Fracture
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Carpal Tunnel Syndrome
- ☐ Joint Disease (Arthritis / Osteoarthritis / Rheumatoid Arthritis / Gout / Hypermobility)
- ☐ Other:

  _____

Cardiovascular

- ☐ Heart Condition:

  _____
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Fainting
- ☐ Cough
- ☐ Emphysema / COPD
- ☐ Phlebitis / Deep Vein Thrombosis / Blood Clots / Embolism / Varicose Veins
- ☐ Abnormal Blood Pressure, Specify:

  _____

  _____
- ☐ Easy Bruising
- ☐ Atherosclerosis / Arteriosclerosis
- ☐ Swollen Glands
- ☐ Lymphoma
- ☐ Lymphedema
- ☐ Other:_____

Endocrine

- ☐ Intolerance to heat / cold
- ☐ Excessive Thirst
- ☐ Hypothyroidism / Hashimoto's
- ☐ Hyperthyroidism / Grave's

GI

- ☐ Nausea
- ☐ Heart Burn
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Yellow Jaundice
- ☐ Increasing Constipation
- ☐ Persistent Diarrhea
- ☐ Blood in Stools
- ☐ Black Stools

Skin

- ☐ Contagious Skin Condition
- ☐ Skin Cancer
- ☐ Open Sore or Wounds
- ☐ Easy Bruising
- ☐ Rash / Eczema / Atopic Dermatitis / Allergies:

  _____

Neurological

- ☐ Epilepsy
- ☐ Stroke
- ☐ Decreased Sensation / Numbness
- ☐ Tingling
- ☐ Other:

  _____

Other

- ☐ Alcohol / Drug Abuse
- ☐ Diabetes
- ☐ Headaches/Migraines
- ☐ Current Fever
- ☐ Cancer:

  _____
- ☐ Artificial Joints:

  _____

Continues on to back

Women Only

- ☐ Abnormal Pap Smear
- ☐ Irregular Periods
- ☐ Bleeding between periods

Are you trying to get pregnant? Y / N
Are you pregnant? Y / N, if yes, how far along are you? _____
Have you reached Menopause? Y / N. What Age? _____

Any Recent Accidents / Injuries (What & Date):

_____

_____

Smoking

Do you currently smoke or have you smoked? **Yes / No**
If yes, please specify the details below (i.e. 10 years, 1 pack/wk.):

_____

Drinking

Do you drink alcohol? **Yes / No**
If yes, how often and how much (i.e. 2 glasses of wine/week):

_____

Medications

Please list any medications that you are currently on along with indication:

_____

_____

Allergies

Please specify any allergies you may have:

_____

_____

Anything else in your medical history we should know?

_____

General Questions

- Please describe the physical nature of your work or duties (i.e. standing for several hours looking down):

  _____

  _____

- List any hobbies or sports you participate in on a regular basis:

  _____

Printed Name of Patient: _____

Signature of Patient: _____ Date: _____