HealthGoals
Chiropractic Center

UPDATE FORM

Date:____/_____/_____

Personal History

First:_____ Middle:____ Last: _____ Gender: Male / Female
Address: _____Apt # _____
City: _____ State: _____ Zip: _____ County: _____ Country: _____
Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____
Social Security #: _____-_____-_____ Birth Date: ____ /_____/_____ Age:_____
Email Address: _____ Sign up for our Email Newsletter? YES NO

Employer

Business Name: _____ Occupation/Job Title: _____
Business Address: _____
Business Phone: (_____)_____-_____ Type of Work:_____

Circle One: Divorced Married Single Separated Widowed
Spouses Name: _____ Spouses Employer:_____
Spouses Occupation: _____ Work Phone# : _____
Ages of Children: _____

How were you referred to our office? _____

Emergency Contact

Name: _____ Phone Number: (_____)_____-_____
Address: _____
Relationship:_____

Who Is Responsible For Your Bill?
☐ Self ☐ Health Insurance ☐ Work. Comp ☐ Auto Ins. ☐ Medicare ☐ Other (be specific):_____
Insurance Carrier: _____ ID #: _____
Insured Person's Name: _____ Group #: _____
Insured Person's Date of Birth: _____ Primary Care Physician: _____
Insured Person's Social Security #: _____-_____-_____

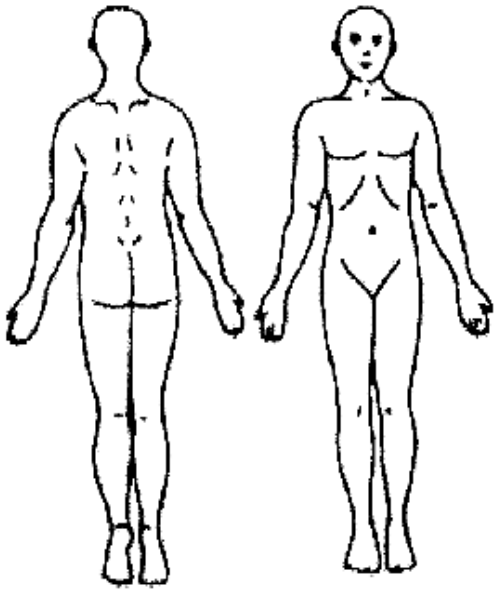
CURRENT HEALTH CONDITION

Chief complaint (Why you are here today):_____
_____
_____

Use the letters below to indicate the type and location of you sensations right now:
A= Ache B=Burning N=Numbness
P=Pins & Needles S=Stabbing O=Other

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →



--When did this complaint/condition begin? _____
--Has it ever occurred before? ☐ Yes ☐ No
If so, When? _____
--Is the condition: ☐ Auto Related ☐ Work Related
☐ No Injury ☐ Other
Explain: _____
_____
--Does your pain radiate? ☐ Yes ☐ No
If yes, describe: _____
--Have you lost time from work? _____

--Please Rate Your Symptoms on a Pain Scale (Zero=No pain) (10=Worst Pain):

RESTING:	0	1	2	3	4	5	6	7	8	9	10
ACTIVE:	0	1	2	3	4	5	6	7	8	9	10

Have you seen other doctors for this condition? □ Yes □ No If yes, Who? (Name) _____
Location of Office: _____ Type of Treatment: _____
Were you satisfied with the results of your treatment? □ Yes □ No Explain: _____
Are you currently taking any prescription medications? □ Yes □ No. If yes, please mark or list below (be specific).
□ Allergy Medication □ Anti-Depressants □ Blood Pressure Medication □ Insulin □ Muscle Relaxers
□ Nerve Pills □ Pain Killers □ Other (please be specific): _____

Do you wear any of the following? □Yes □ No. If yes, please mark: □ Heel Lifts □ Innersoles □ Arch Supports □ Orthotics

Please list any other conditions you feel we should know about – even if unrelated: _____
_____
_____

What is your goal for care at our office? What would you like to be able to do better and/or easier than you are doing right now?
_____
_____

Please Specify the Effect of your Current Condition on the following Daily Activities:

Bending :	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Caring for Infirm Family:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Carrying Groceries:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Change Posnï Sit-Stand:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Climb Stairs:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Driving:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Ext Computer Use:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Feeding Yourself:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Household Chores:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Kneeling:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Lift Children:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Lifting (Generalized):	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Daily Pet Care:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Reading (Concentration):	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Self Careï Bathing:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Self Careï Dressing:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Self Careï Shaving:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Sexual Activities:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Sleep:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Static Sitting:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Static Standing:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Walking:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Yard Work:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform

Please Specify the Effect of your Current Condition on your Recreational Activities:

_____	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (limited)	□ **Sev** Unable to Perform
_____	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (limited)	□ **Sev** Unable to Perform
_____	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (limited)	□ **Sev** Unable to Perform
_____	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (limited)	□ **Sev** Unable to Perform

REVIEW OF SYSTEMS--**Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.**
– Please fill out all of the sections, even if "DENY".

Constitutional: **I…** ☐ **Deny Any Constitutional Issue (s) (Pertaining to the Body as a Whole)**
☐ **Chills** ☐ **Daytime Somnolence (Drowsiness)** ☐ **Fatigue** ☐ **Fever** ☐ **Night Sweats**
☐ **Weight Gain** ☐ **Weight Loss**

Eyes/Vision: **I…** ☐ **Deny Any Eyes/Vision Issue (s)**
☐ **Blindness** ☐ **Blurred Vision** ☐ **Cataracts** ☐ **Change in vision** ☐ **Double Vision**
☐ **Eye Pain** ☐ **Field Cuts (visual field defect)** ☐ **Glaucoma** ☐ **Itching (around the eyes)** ☐ **Photophobia**
☐ **Tearing** ☐ **Wears Glasses and/or Contact lenses**

Ears, Nose and Throat: **I…** ☐ **Deny Any Ears, Nose and Throat Issue (s)**
☐ **Bleeding** ☐ **Dental Implants** ☐ **Dentures** ☐ **Difficulty Swallowing** ☐ **Discharge**
☐ **Dizziness** ☐ **Ear Drainage** ☐ **Ear Infection(s)** ☐ **Ear Pain** ☐ **Fainting**
☐ **Headaches** ☐ **Head Injury (history of)** ☐ **Hearing Loss** ☐ **Hoarseness** ☐ **Loss of Smell**
☐ **Nasal Congestion** ☐ **Nose bleeds (frequent)** ☐ **Post Nasal Drip** ☐ **Rhinorrhea (Runny nose)** ☐ **Sinus Infections**
☐ **Snoring** ☐ **Sore Throats (frequent)** ☐ **Tinnitus (Ringing in Ears)** ☐ **TMJ problems**

Respiration: **I…** ☐ **Deny Any Respiratory Issue (s)**
☐ **Asthma** ☐ **Cough** ☐ **Coughing up blood** ☐ **Shortness of Breath** ☐ **Sputum Production** ☐ **Wheezing**

Cardiovascular: **I…** ☐ **Deny Any Cardiovascular Issue (s)**
☐ **Angina (chest pain or discomfort)** ☐ **Chest Pain** ☐ **Claudication (leg pain or achiness)** ☐ **Heart Murmor**
☐ **Heart Problems** ☐ **Orthopnea (difficulty breathing while lying down)** ☐ **Palpitations (irregular or forceful beating of the heart)**
☐ **Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath)** ☐ **Shortness of Breath with Exertion or Exercise**
☐ **Swelling of Legs** ☐ **Ulcers** ☐ **Varicose Veins**

Gastrointestinal: **I…** ☐ **Deny Any Gastrointestinal Issue (s)**
☐ **Abdominal Pain** ☐ **Belching** ☐ **Black, Tarry Stools** ☐ **Constipation** ☐ **Diarrhea**
☐ **Difficulty Swallowing** ☐ **Heartburn** ☐ **Hemorrhoids** ☐ **Indigestion** ☐ **Jaundice (yellowing of the skin)**
☐ **Nausea** ☐ **Rectal Bleeding** ☐ **Abnormal Stool Caliber (quality)** ☐ **Abnormal Stool Color**
☐ **Abnormal Stool Consistency** ☐ **Vomiting** ☐ **Vomiting Blood**

Female: **I…** ☐ **Deny Any Female Issue (s)**
☐ **Birth Control Therapy** ☐ **Breast Lumps/Pain** ☐ **Burning Urination** ☐ **Cramps** ☐ **Frequent Urination**
☐ **Hormone Therapy** ☐ **Irregular Menstruation** ☐ **Urine Retention** ☐ **Vaginal Bleeding** ☐ **Vaginal Discharge**

Male: **I…** ☐ **Deny Any Male Issue (s)**
☐ **Burning Urination** ☐ **Erectile Dysfunction** ☐ **Frequent Urination** ☐ **Hesitancy/Dribbling** ☐ **Prostate Problems**
☐ **Urine Retention**

Endocrine: **I…** ☐ **Deny Any Endocrine Issue (s)**
☐ **Cold Intolerance** ☐ **Diabetes** ☐ **Excessive Appetite** ☐ **Excessive Hunger** ☐ **Excessive Thirst**
☐ **Frequent Urination** ☐ **Goiter** ☐ **Hair Loss** ☐ **Heat Intolerance** ☐ **Unusual Hair Growth**
☐ **Voice Changes**

Skin: **I…** ☐ **Deny Any Skin Issue (s)**
☐ **Changes in Nail Texture** ☐ **Changes in Skin Color** ☐ **Hair Growth** ☐ **Hair Loss** ☐ **Hives** ☐ **Itching**
☐ **Paresthesia (numbness, prickling, or tingling)** ☐ **Rash** ☐ **History of Skin Disorders** ☐ **Skin Lesions/Ulcers** ☐ **Varicosities**

Nervous System: **I…** ☐ **Deny Any Nervous System Issue (s)**
☐ **Dizziness** ☐ **Facial Weakness** ☐ **Headaches** ☐ **Limb Weakness** ☐ **Loss of Consciousness**
☐ **Loss of Memory** ☐ **Numbness** ☐ **Seizures** ☐ **Sleep Disturbance** ☐ **Slurred Speech**
☐ **Stress** ☐ **Strokes** ☐ **Tremors** ☐ **Unsteadiness of Gait**

Psychologic: **I…** ☐ **Deny Any Psychologic Issue (s)**
☐ **Anhedonia (inability to experience joy or enjoy life)** ☐ **Anxiety** ☐ **Appetite Changes** ☐ **Behavioral Change(s)**
☐ **Bipolar Disorder** ☐ **Confusion** ☐ **Convulsions** ☐ **Depression** ☐ **Insomnia** ☐ **Memory Loss**
☐ **Mood Change(s)**

Allergy: I… □ Deny Any Allergy Issue (s)
□ Anaphylaxis (history of) □ Food Intolerance □ Itching □ Nasal Congestion □ Sneezing

Hematology: I… □ Deny Any Hematologic Issue (s)
□ Anemia □ Bleeding □ Blood Clotting □ Blood Transfusion(s) □ Bruises easily □ Fatigue □ Lymph Node Swelling

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PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness: I… □ Deny Any Childhood Illness (es)

□ ADD	□ Allergies/Hayfever	□ Asthma	□ Atopic Dermatitis (Eczema)	□ Bedwetting
□ Cerebral Palsy	□ Chicken Pox	□ Depression	□ Diabetes	□ Ear Infections
□ Fetal Drug Exposure	□ Food Allergies	□ Headaches	□ Hepatitis	□ HIV
□ Measles	□ Mumps	□ Rash	□ Scoliosis	□ Seizure Disorder
□ Sickle Cell Anemia	□ Spina Bifida	□ Other (please describe): _____		

Adult Illness: I… □ Deny Any Adult Illness (es)

□ Alzheimers	□ Anemia	□ Arthritis	□ Asthma	□ Cancer
□ Chicken Pox	□ Crohn's/Colitis	□ CRPS (RSD)	□ CVA (stroke)	□ Cystic Kidney Disease
□ Depression	□ Diabetes (Insulin)	□ Diabetes (Non insulin)	□ Ear Infections (frequent)	□ Emphysema
□ E ye Problems	□ Fibromyalgia	□ Heart Disease	□ Hepatitis	□ HIV
□ Hypertension	□ Influenzal Pneumonia	□ Liver Disease	□ Lung Disease	□ Lupus Erythema (discoid)
□ Lupus Erythema (systemic)	□ Multiple Sclerosis	□ Parkinson's Disease	□ Pleurisy	□ Pneumonia
□ Psychiatric Problems	□ Scoliosis	□ Seizure Disorder	□ Shingles	□ STD's (unspecified)
□ Suicide Attempt(s)	□ Thyroid Problems	□ Vertigo		

□ Past history of similar symptoms to your current condition □ Other Illness (please be specific): _____

Surgeries: I… □ Deny Any Surgery (ies)

□ Angioplasty	□ Appendectomy	□ Caesarian Section	□ Cardiac Catheterization	□ Carpal Tunnel Repair
□ Coronary Artery Bypass	□ Cosmetic	□ D & C	□ Dental Surgery	□ Gallbladder
□ Hemorrhoidectomy	□ Hernia Repair	□ Hysterectomy	□ Joint Reconstruction	□ Joint Replacement
□ Laminectomy	□ Mastectomy	□ Pacemaker Insertion	□ Rotator Cuff	□ Spinal Fusion
□ Tonsilectomy	□ Other (please be specific): _____			

Ob/Gyn: I… □ Deny Any Ob/Gyn Issue (s)
I… □ have never been pregnant □ have been pregnant in the past □ am currently pregnant

_____ Number of pregnancies	_____ Number of complicated pregnancies	_____ Number of uncomplicated pregnancies
_____ Number of miscarriages	_____ Number of terminated pregnancies	_____ Number of Epidural Injections
_____ Number of C-Sections	_____ Number of vaginal deliveries	

Menstrual History: Age of Onset _____
My menses is □ Regular □ Irregular; I am currently in □ Metaphase □ Menopause; Date of Last Menses _____/_____/_____

Injuries: I… □ Deny Any Injury (ies)

□ Back Injury	□ Broken Bones	□ Severe Fall	□ Fracture	□ Disability
□ Head Injury	□ Industrial Accident	□ Joint Injury	□ Severe Laceration	□ Motor Vehicle Accident
□ Mild/Moderate Soft Tissue Injury		□ Severe Soft Tissue Injury		

Immunizations: I… □ Deny Any Immunization (s)

□ DTaP(diptheria, tetanus, and pertussis)	□ Flu	□ Hepatitis A	□ Hepatitis B	□ Hepatitis C
□ Influenza	□ IPV (Polio)	□ MMR (measles, mumps, and rubella)	□ Pneumococcal	
□ PPD (Mantoux Test-TB)	□ Small Pox	□ TB	□ Varivax (chicken pox)	□ Whooping Cough (Pertussis)

Non-Drug Allergies: I… □ Deny Any Non-Drug Allergy (ies)
□ Animals □ Dairy □ Eggs □ Food Coloring □ Mold □ Pollen □ Wheat
□ Other (please be specific): _____
Type of Reaction: □ Swelling □ Anaphylaxis □ GI Disturbance □ Headache □ Joint Pain □ Rash □ Shortness of Breath
□ Other: _____

FAMILY HISTORY

Condition (Please be specific)

General Family □ Alive □ Deceased; □ Normally Developed □ No Significant Disease □ Has/Had: _____
Father □ Alive □ Deceased; □ Normally Developed □ No Significant Disease □ Has/Had: _____
Mother □ Alive □ Deceased; □ Normally Developed □ No Significant Disease □ Has/Had: _____
Paternal Grandfather □ Alive □ Deceased; □ Normally Developed □ No Significant Disease □ Has/Had: _____
Paternal Grandmother □ Alive □ Deceased; □ Normally Developed □ No Significant Disease □ Has/Had: _____
Maternal Grandfather □ Alive □ Deceased; □ Normally Developed □ No Significant Disease □ Has/Had: _____
Maternal Grandmother □ Alive □ Deceased; □ Normally Developed □ No Significant Disease □ Has/Had: _____
Son (s) □ Alive □ Deceased; □ Normally Developed □ No Significant Disease □ Has/Had: _____
Daughter (s) □ Alive □ Deceased; □ Normally Developed □ No Significant Disease □ Has/Had: _____
Brother (s) □ Alive □ Deceased; □ Normally Developed □ No Significant Disease □ Has/Had: _____
Sister (s) □ Alive □ Deceased; □ Normally Developed □ No Significant Disease □ Has/Had: _____

SOCIAL HISTORY

Alcohol: □ **Never** □ **Social Consumption only** □ **Beer** □ **Liquor** □ **Wine ; _____ oz ____ glasses;** □ **Day** □ **Week** □ **Month**

Diet (Please mark all that apply): □ **High Fat** □ **High Fiber** □ **High Protein** □ **High Salt** □ **Low Calorie** □ **Low Carb** □ **Low Fiber** □ **Low Salt** □ **Low Sugar**

Education (Please mark the highest level completed): □ **Preschool** □ **Elementary** □ **Middle** □ **Junior High** □ **Votech** □ **In High School** □ **Did Not Finish High School** □ **High School Diploma** □ **Post High School Classes** □ **Assoc/Technical Degree** □ **In College** □ **College Degree** □ **In Graduate School** □ **Graduate Degree** □ **Doctorate** □ **Other: _____**

Drugs: □ **Deny any illegal drug use** □ **Deny use of IV drugs** □ **Have not used drugs since _____** □ **Have used drugs for _____**

Tobacco: □ **Deny Tobacco Use** □ **Do not smoke cigars, cigarettes or pipe** □ **Live with a smoker** □ **Quit smoking** □ **Smoke; # _____ per** □ **Day** □ **Week** □ **Month** □ **Chew; #_____cans per** □ **Day** □ **Week** □ **Year**