

**PATIENT HISTORY FORM** DR. AMANDA S. ARMINGTON, CHIROPRACTIC

PHYSICIAN

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

DATE PROBLEM BEGAN: \_\_\_/\_\_\_/\_\_\_

PLEASE DESCRIBE YOUR PROBLEM AND HOW IT BEGAN.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WAS THIS WORK RELATED? DUE TO A MOTOR VEHICLE ACCIDENT?

DID THE PAIN COME ON: IMMEDIATELY GRADUALLY

IS YOUR PAIN: GETTING WORSE GETTING BETTER STAYING THE SAME

IS YOUR PAIN: CONSTANT COMES & GOES

IS YOUR PAIN: SHARP/STABBING THROBBING ACHES DULL SORE WEAK NUMBNESS  
SHOOTING BURNING TINGLING OTHER \_\_\_\_\_

WHAT LEVEL IS YOUR PAIN: NONE 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE  
PAIN

CAN YOU PERFORM REGULAR DAILY ACTIVITIES? YES, ALL YES, ONLY WITH HELP NOT  
AT ALL PLEASE LIST DIFFICULTIES: \_\_\_\_\_

WHAT MAKES YOUR PROBLEM BETTER?

\_\_\_\_\_  
\_\_\_\_\_

WHAT MAKES YOUR PROBLEM WORSE?

\_\_\_\_\_

HAVE YOU EXPERIENCED THIS BEFORE? YES NO IF YES, PLEASE DESCRIBE BELOW  
(WHEN/WHAT DID YOU DO FOR IT?)

\_\_\_\_\_

HAVE YOU HAD XRAYS/MRI/OTHER TESTS IN THE PAST FOR THIS CONDITION?

\_\_\_\_\_

PLEASE MARK AREA(S) OF PAIN OR DISCOMFORT ON THE DRAWINGS BELOW:

ACHING = A

BURNING = B

NUMBNESS = N

PINS & NEEDLES = P

STABBING = S

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

REVIEW OF SYMPTOMS (please check any/all that apply):

FEVER	EXTREME FATIGUE	UNEXPLAINED WEIGHT LOSS/GAIN	
NIGHT PAIN	NIGHT SWEATS	SORE THROAT	COUGH
VISION CHANGE	CHEST PAIN	VOMITING	NAUSEA
BLEEDING	DIARRHEA	MUSCLE WEAKNESS	RASH
HOT FLASHES	DIFFICULTY SWALLOWING	DIFFICULTY BREATHING	INFECTION
LOSS OF BOWEL/BLADDER CONTROL		DIFFICULTY SLEEPING	

PAST MEDICAL HISTORY (please check any/all that apply):

NECK PAIN	UPPER BACK PAIN	LOWER BACK PAIN	HIP PAIN
SHOULDER PAIN	HAND/WRIST PAIN	FOOT/ANKLE PAIN	KNEE PAIN
JAW PAIN	DIZZINESS	HEADACHES	DIABETES
IRREGULAR BOWEL HABITS/CONSTIPATION		FREQUENT/PAINFUL URINATION	
CANCER	ARTHRITIS	KIDNEY DISEASE/STONES	HEPATITIS
STROKE	HIGH BLOOD PRESSURE	DIVERTICULITIS	ANEMIA
ASTHMA	DEPRESSION/ANXIETY	JOINT PAIN/STIFFNESS	ALLERGIES
AIDS/HIV	LUNG PROBLEMS	HEART ATTACK	SEIZURES
CRAMPS	IRREGULAR MENSES	HEAVY MENSES	PMS
PREGNANCY _____	BIRTHS _____	PROBLEMS	

OTHER \_\_\_\_\_

FAMILY MEDICAL HISTORY: HEART DISEASE    CANCER    STROKE    ARTHRITIS    HIGH BLOOD PRESSURE    DIABETES    SCOLIOSIS    LUPUS  
LIVING PARENTS? MOTHER YES NO; DIED AT AGE \_\_\_\_\_ OF \_\_\_\_\_  
FATHER YES NO; DIED AT AGE \_\_\_\_\_ OF \_\_\_\_\_

LIFESTYLE HABITS: ALCOHOL    TOBACCO    DRUGS    COFFEE/TEA    SODA    SUGAR    BIRTH CONTROL PILLS \_\_\_\_\_

CURRENT MEDICATIONS/DOSAGES \_\_\_\_\_

SURGERIES/HOSPITALIZATIONS \_\_\_\_\_

INJURIES/FRACTURES/DISLOCATIONS \_\_\_\_\_

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Other Information:

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