Patient Name: ID #

Health History

Check any of the following conditions that you currently have or ever had in the past, with the date:

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition
❑	❑	AIDS / HIV	❑	❑	Epilepsy	❑	❑	Parkinson's Disease
❑	❑	Alcoholism	❑	❑	Fibromyalgia	❑	❑	Pneumonia
❑	❑	Allergies	❑	❑	Fractures	❑	❑	Polio
❑	❑	Anemia	❑	❑	German Measles	❑	❑	Prostate Problems
❑	❑	Anorexia / Bulimia	❑	❑	Gall Bladder Problems	❑	❑	Prosthesis
❑	❑	Appendicitis	❑	❑	Glaucoma	❑	❑	Recurrent Headaches
❑	❑	Arthritis	❑	❑	Goiter	❑	❑	Rheumatic Fever
❑	❑	Asthma / Hay Fever	❑	❑	Gout	❑	❑	Rheumatoid Arthritis
❑	❑	Bleeding Disorders	❑	❑	Heart Disease	❑	❑	Scarlet Fever
❑	❑	Blood Pressure Problems	❑	❑	Hepatitis	❑	❑	Scoliosis
❑	❑	Breast Lump	❑	❑	Hernia	❑	❑	Sexual Dysfunction
❑	❑	Bronchitis	❑	❑	Herpes	❑	❑	Sinus Problems
❑	❑	Bursitis	❑	❑	High Cholesterol	❑	❑	Sleep Disorder
❑	❑	Cancer	❑	❑	Kidney Infections	❑	❑	Smallpox
❑	❑	Cataracts	❑	❑	Kidney Disease	❑	❑	Stroke
❑	❑	Chemical Dependency	❑	❑	Kidney/Bladder Stones	❑	❑	Suicide Attempt
❑	❑	Chicken Pox	❑	❑	Liver Disease	❑	❑	Thyroid Problems
❑	❑	Chronic Fatigue	❑	❑	Lung Disease	❑	❑	Tonsillitis
❑	❑	Colitis	❑	❑	Measles	❑	❑	Tuberculosis
❑	❑	Convulsions	❑	❑	Migraine Headaches	❑	❑	Tumor / Growth
❑	❑	Daily Headaches	❑	❑	Mononucleosis	❑	❑	Typhoid Fever
❑	❑	Diabetes	❑	❑	Multiple Sclerosis	❑	❑	Ulcer
❑	❑	Digestive Problems	❑	❑	Mumps	❑	❑	Vaginal Infections
❑	❑	Disc Problems	❑	❑	Muscular Dystrophy	❑	❑	Venereal Disease
❑	❑	Ear Infection(s)	❑	❑	Osteoporosis	❑	❑	Whooping Cough
❑	❑	Emphysema	❑	❑	Pacemaker	❑	❑	Other ______________________

Injuries/ Operations

Please list any procedures or injuries you have had, with the date:

❑ Appendectomy _______	❑ C-section(s) __________	❑ Concussion ___________	❑ Cancer (type) ___________________
❑ Gall bladder __________	❑ Fracture/ break _______	❑ Hysterectomy _________	❑ Kidney stones ___________________
❑ Knee surgery _________	❑ Pacemaker ___________	❑ Pregnancy(s) __________	❑ Shoulder surgery ________________
❑ Sinus surgery _________	❑ Spinal surgery ________	❑ Tonsillectomy _________	❑ Vasectomy ______________________
❑ Whiplash ____________			

Please list any other injuries / operations or conditions:

____

____

____

Family History

Please tell us about the health of your immediate family members:

Relative	Age	Age at death	State of health	Illness
Spouse/partner	________	___________	____________	________________________________
Mother	________	___________	____________	________________________________
Father	________	___________	____________	________________________________
Sister 1	________	___________	____________	________________________________
Sister 2	________	___________	____________	________________________________
Brother 1	________	___________	____________	________________________________
Brother 2	________	___________	____________	________________________________

Please tell us anything else you would like us to know about your family medical history:

____

____

____

MW ____

© Great River Chiropractic Clinic

410-832-8888

Patient Name: ID #

Review of Systems

Please check any condition that you currently have or have had in the last 12 months ONLY:

Cardiovascular

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition
❑	❑	Angina	❑	❑	Prone to bruising	❑	❑	High blood prs.	❑	❑	High cholesterol
❑	❑	Low blood prs.	❑	❑	Murmur	❑	❑	Poor circulation			

Digestive

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition
❑	❑	Acid reflux	❑	❑	Anorexia/ bulimia	❑	❑	Bloating	❑	❑	Bloody/ black stool
❑	❑	Constipation	❑	❑	Diarrhea	❑	❑	Food sensitivities	❑	❑	Heartburn

Endocrine

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition
❑	❑	Fatigue	❑	❑	Frequent infection	❑	❑	Hypoglycemia	❑	❑	Immune disorders
❑	❑	Low energy	❑	❑	Low libido	❑	❑	Swollen glands	❑	❑	Thyroid issues

Females only

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition
❑	❑	Excessive pain	❑	❑	Hot flashes	❑	❑	Irregular periods	❑	❑	Nipple discharge
❑	❑	PMS symptoms	❑	❑	Vaginal discharge	❑	❑	Date of last period ________________	❑	❑	Date of last gyn exam __________________

Genitourinary

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition
❑	❑	Bedwetting	❑	❑	Kidney stones	❑	❑	Infertility	❑	❑	Painful urination

General

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition
❑	❑	Anxiety	❑	❑	Depression	❑	❑	Fainting	❑	❑	Fatigue
❑	❑	Poor appetite	❑	❑	Sudden weight change						

Males only

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition
❑	❑	Breast lump	❑	❑	Erectile dysfc.	❑	❑	Prostate issues	❑	❑	Sores
❑	❑	Date of last prostate exam ________________									

Musculoskeletal

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition
❑	❑	Arthritis (osteo)	❑	❑	Arthritis (rheum)	❑	❑	Elbow/wrist	❑	❑	Foot/ ankle
❑	❑	Hip	❑	❑	Knee	❑	❑	Low back	❑	❑	Mid back
❑	❑	Neck	❑	❑	Osteoporosis	❑	❑	Poor Posture	❑	❑	TMJ
❑	❑	Weakness									

Neurological

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition
❑	❑	Balance	❑	❑	Dizziness						
❑	❑	Headache	❑	❑	Numbness	❑	❑	Tingling	❑	❑	Tremor

Respiratory

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition
❑	❑	Allergies	❑	❑	Apnea	❑	❑	Asthma	❑	❑	Emphysema
❑	❑	Hay fever	❑	❑	Pneumonia	❑	❑	Shortness of breath	❑	❑	Sinus problems

Sensory

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition			Condition
❑	❑	Blurred vision	❑	❑	Chronic ear infc.	❑	❑	Hearing loss	❑	❑	Loss of smell
❑	❑	Loss of taste	❑	❑	Ringing in ears						

Skin

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition
❑	❑	Acne	❑	❑	Eczema	❑	❑	Excessively dry	❑	❑	Hair loss
❑	❑	Psoriasis	❑	❑	Rash	❑	❑	Skin cancer			

MW ____

© Great River Chiropractic Clinic
410-832-8888

Patient Name:

ID #

Medications / Supplements

Please list all medications (Rx and OTC), supplements (vitamins, herbs, minerals, etc) you are currently using or have used in the last 12 months.

Med / Suppl.	Rationale	Dosage	Date Started	Prescribing Provider

Please list any adverse reactions to medications, supplements, vaccines and any known food sensitivities:

____

____

____

____

____

Please list any past or present exposure to harmful chemicals, heavy metals or molds that you know of:

____

____

____

____

Have you been on antibiotics for a prolonged period?

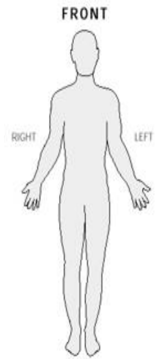
Type (if known)	Reason	Length of time used

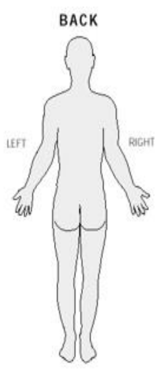
Any household pets or other animals you of other family members are in close contact with?

____

Please tell us about your birth: ❑ Vaginal delivery ❑ C-section ❑ Forceps / vacuum ❑ Respiratory distress ❑ Other: ______________________

Please indicate the **location of any scars or piercings**.





MW ____

© Great River Chiropractic Clinic
410-832-8888

Patient Name: ID #

Lifestyle

Briefly describe what you eat on a typical day: Approximate time:

Breakfast: ______________________________ ________________

Lunch: ______________________________ ________________

Dinner: ______________________________ ________________

Snacks: ______________________________ ________________

Alcohol	❑ Daily	❑ Weekly	Qty ________
Coffee	❑ Daily	❑ Weekly	Qty ________
Tobacco	❑ Daily	❑ Weekly	Qty ________
Sugar	❑ Daily	❑ Weekly	Qty ________
Fast food	❑ Daily	❑ Weekly	Qty ________ What kind?____________
Soda	❑ Daily	❑ Weekly	Qty ________ What kind?____________
Water	❑ Daily		Qty ________

What are your top two food indulgences? ______________________________

Does your current state of physical health interfere with your daily life? ❑ Yes ❑ No

Details: ______________________________

Do you live/work in a damp or moldy home/office? ❑ Yes ❑ No

How much time using a work station? _______ Laptop? _______ Tablet? _______ Smartphone? _______

How much time are you in the car? _______ In front of the tv? _______

Activity level during the week ❑ Sedentary ❑ Light ❑ Moderate ❑ Heavy

Does your current state of physical health interfere with your work activities? ❑ Yes ❑ No

Details: ______________________________

Please rate your lifestyle health on a scale of 1 (horrible) to 10 (excellent): ________

Reason(s): ______________________________

Describe your stress level ❑ Low ❑ Moderate ❑ High

Reason(s): ______________________________

How do you relax or relieve stress? ______________________________

Please describe your exercise activities:

Type(s): ______________________ Frequency: _______ per week/month

Type(s): ______________________ Frequency: _______ per week/month

Activity level on weekends ❑ Sedentary ❑ Light ❑ Moderate ❑ Heavy

Does your current state of physical health interfere with your leisure activities? ❑ Yes ❑ No

Details: ______________________________

What are your top two summer leisure activities?______________________________

What are your top two winter leisure activities? ______________________________

How frequently do you travel: ❑ Annually ❑ Semi-annually ❑ Monthly ❑ Weekly

Describe your sleep pattern: Wake time _______ Bed time _______ Avg. hours per night ________

Naps? ❑ Yes ❑ No Frequency: _______

Do you feel: ❑ Rested on awakening ❑ Tired on awakening

Do you: ❑ Have trouble getting to sleep ❑ Awaken during night, once or more? ________

❑ Sleep near an electronic device (ex: smartphone) ❑ Sleep in total darkness

Typical sleep position: ❑ Side ❑ Back ❑ Stomach

Mattress Type: ❑ Firm ❑ Soft ❑ Coil ❑ Memory foam / Latex

❑ Adjustable ❑ Other ____________

Pillow Type: ❑ Firm ❑ Soft ❑ Feather ❑ Synthetic ❑ Orthopedic

MW ____

© Great River Chiropractic Clinic
410-832-8888

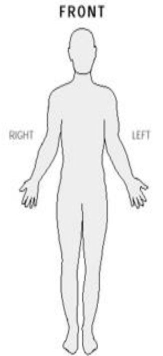
Patient Name: ID #

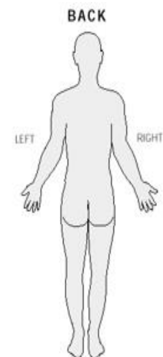
What brings you here today?

Primary Complaint	Secondary Complaint	Other Complaint
______________________	______________________	______________________
Experienced before? ❑Yes ❑No	Experienced before? ❑Yes ❑No	Experienced before? ❑Yes ❑No
Chronic problem? ❑Yes ❑No	Chronic problem? ❑Yes ❑No	Chronic problem? ❑Yes ❑No
Getting worse? ❑Yes ❑No	Getting worse? ❑Yes ❑No	Getting worse? ❑Yes ❑No
Due to: ❑Accident ❑Injury	Due to: ❑Accident ❑Injury	Due to: ❑Accident ❑Injury
Date of onset: ________	Date of onset: ________	Date of onset: ________
How it started: ________	How it started: ________	How it started: ________
Worse in ❑AM ❑PM	Worse in ❑AM ❑PM	Worse in ❑AM ❑PM
What relieves it? ________	What relieves it? ________	What relieves it? ________
What makes it worse? ________	What makes it worse? ________	What makes it worse? ________
Prior treatments:	Prior treatments:	Prior treatments:
❑Chiropractic ❑Rx Meds	❑Chiropractic ❑Rx Meds	❑Chiropractic ❑Rx Meds
❑Massage ❑OTC Meds	❑Massage ❑OTC Meds	❑Massage ❑OTC Meds
❑Acupuncture ❑Surgery	❑Acupuncture ❑Surgery	❑Acupuncture ❑Surgery
❑Physical Therapy ❑Ice/Heat	❑Physical Therapy ❑Ice/Heat	❑Physical Therapy ❑Ice/Heat
❑Other: ________	❑Other: ________	❑Other: ________

Please describe any musculoskeletal symptoms using these abbreviations.

P = Sharp Pain
D = Dull Pain
B = Burning
T = Tingling





Activities of Daily Living

What effect does your current condition interfere with your daily function?

	None	Mild	Moderate	Severe
Sitting	❑	❑	❑	❑
Getting out of chair	❑	❑	❑	❑
Standing	❑	❑	❑	❑
Walking	❑	❑	❑	❑
Lying down	❑	❑	❑	❑
Bending backward	❑	❑	❑	❑
Bending forward	❑	❑	❑	❑
Climbing stairs	❑	❑	❑	❑
Using a computer	❑	❑	❑	❑
Getting in / out of car	❑	❑	❑	❑
Turning head	❑	❑	❑	❑

	None	Mild	Moderate	Severe
Household chores	❑	❑	❑	❑
Yard work	❑	❑	❑	❑
Reaching overhead	❑	❑	❑	❑
Lifting objects	❑	❑	❑	❑
Showering / bathing	❑	❑	❑	❑
Dressing	❑	❑	❑	❑
Sex life	❑	❑	❑	❑
Falling asleep	❑	❑	❑	❑
Staying asleep	❑	❑	❑	❑
Concentrating	❑	❑	❑	❑
Exercising	❑	❑	❑	❑

Please provide any additional information: ______________________

MW ____

© Great River Chiropractic Clinic
410-832-8888

Patient Name: ID #

Acknowledgments:

Please read each statement and initial your agreement.

Initials _________ I instruct you to deliver the care that, in your professional judgment, can best help me in the restoration of my health.

Initials _________ I grant permission to be called to confirm or reschedule appointments and to be sent correspondence in the form of cards, email, letters, texts, etc.

Initials _________ I understand that I may request a copy of the HIPAA policy at any time. I understand that it describes how my personal health information is protected and when my information may be released on my behalf.

Initials _________ I understand that x-ray examinations may be indicated as part of my care. I also understand that I have the right to waive an x-ray exam.

Initials _________ I realize that x-ray examinations may be hazardous to an unborn child and certify to the best of my knowledge that I am not pregnant.
Date of last menstrual period: __________ (if applicable)

Initials _________ I acknowledge that my health insurance is a contract between myself and my provider. I understand that any questions I have about my coverage should be directed to my provider.

Initials _________ I understand that payment for all services are due in full at the time services are rendered.

Initials _________ Should my account be referred to an agency or an attorney for collection, I understand that I will be responsible for all collection costs, attorney's fees and court costs.

Initials _________ I understand that arriving 10 minutes past my scheduled appointment time is equivalent to a missed appointment, and I will most likely need to reschedule.

Initials _________ I agree that I am responsible for a $25 missed appointment fee in the event I do not give the required 24 hour notice, or a $40 fee if I miss my appointment without notice. I also agree that I am responsible for a $35 returned check fee.

Initials _________ (if applicable) **Consent to evaluate and adjust a minor child:** I, ______________________being the parent or legal guardian of ____ age _______, have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Initials _________ To the best of my knowledge and ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of any of my health concern(s).

____ __________________

Patient or Guardian Signature Date

MW ____

© Great River Chiropractic Clinic
410-832-8888