ADVANCED CHIROPRACTIC ASSOCIATES, PLLC

7349 Chapman Highway, Knoxville, TN 37920

Health History

Name: **Chart #:** **Today's Date:** **Date of Onset:**

Please select all choices that apply to the patient

☐ Abdominal Pain	☐ Colitis	☐ Headaches	☐ Irritable Colon	☐ Neck Pain	☐ Rheumatoid Arthritis
☐ Allergies	☐ Colon Cancer	☐ Heart Attacks	☐ Kidney Disease	☐ Osteoporosis	☐ Scoliosis
☐ Aortic Anuerysm	☐ Diabetes	☐ Heart Disease	☐ Leg Pain	☐ Painful Urination	☐ Shoulder Pain
☐ Arthritis	☐ Dislocated joints	☐ High Blood Pressure	☐ Liver Disease	☐ Peptic Ulcer	☐ Sinus Trouble
☐ Asthma	☐ Dizziness	☐ Hip Pain	☐ Low Blood Pressure	☐ PMS	☐ Spinal Disc Disorder
☐ Bone Cancer	☐ Duodenum Ulcer	☐ Hypertension	☐ Lung Cancer	☐ Polio	☐ Stomach Ulcer
☐ Breast Cancer	☐ Epilepsy	☐ Hypothyroidism	☐ Lung Disease	☐ Prostate Cancer	☐ Stroke
☐ Cancer	☐ Fainting	☐ Irregular Bowel Habits	☐ Migraine	☐ Prostate Promblems	☐ Upper Back Pain
☐ Chest Pain	☐ Gouty Arthritis	☐ Irregular Menstrual	☐ Multiple Sclerosis	☐ Rectal Cancer	

Medications:

Supplements/Vitamins:

Please list Allergies and Your Reaction to the Allergy

Allergy	Reaction
Allergy	Reaction
Allergy	Reaction

Who is/was your most recent general Physician?

Past Surgical History:

Current Complaint:

What is your current complaint? (Why are you seeking treatment?)

How severe is this problem?

- ☐ Mild
- ☐ Mild to Moderate
- ☐ Moderate
- ☐ Moderately Severe
- ☐ Severe

How frequently?

- ☐ Constant
- ☐ Occasional
- ☐ Intermittent
- ☐ Frequent

On a 1-10 Scale, how would you rate your pain?

1 2 3 4 5 6 7 8 9 10 **(10=most painful, 1=least painful)**

When was the onset of this problem?

☐ Gradual	☐ About a day ago	☐ About a month ago	
☐ Sudden	☐ Several Days ago	☐ Several months ago	
☐ Insidious	☐ About a week ago	☐ About a year ago	
	☐ Several Weeks ago	☐ Several years ago	

Select each choice that applies to you

Movement

☐ Cramps	☐ Spasm
☐ Inflexibility	☐ Stiffness
☐ Restricted Movement	

Select each choice that applies to you

Sensation

☐ Crawling	☐ Pins and needles	
☐ Dead	☐ Prickly	
☐ Numb	☐ Tingling	

Select the type of pain that best describes your complaint

☐ Achy	☐ Numb Ache	☐ Shooting
☐ Burning	☐ Pounding	☐ Stabbing
☐ Dull	☐ Pulsating	☐ Stinging
☐ Excruciating	☐ Sharp	☐ Throbbing

- ☐ Usually better in the morning
- ☐ Usually better in the day
- ☐ Usually better at night

Please indicate everthing that makes you feel worse or aggravates your condition

I understand that the information I have provided is current and complete to the best of my knowledge

Signature: