Bull Run Chiropractic Clinic
38916 Proctor Blvd.
Sandy, OR 97055

Phone: 503-668-3530
Fax: 503-668-3541

General Health History

Name: ____ Date: ______________________

Date of Birth: _____________________

Reason for seeking care: ____

How long have you noticed this?: ____

How did it start, any particular injury?: ____

Have you noticed this in your past history?: ☐ Yes ☐ No

Is your pain/discomfort constant or does it come and go?: ☐ Constant ☐ Comes and Goes

Are your symptoms worse at a certain time of day?: ____

Is your pain sharp, dull, achy, etc? What words would you use to describe your pain/discomfort?:

____

Rate your pain 0-10 (0 = No Pain, 10 = Worst Pain Imaginable): __________________ out of 10

Do you experience headaches?: ☐ Yes ☐ No How often?: ____________________ per ____________________

How long do the headaches last?: ______________________________

What makes your pain worse? Name three things: 1) _________________ 2) _______________ 3) ________________

What helps make your pain better if anything?: ____

Check the boxes if you have experienced any of the following?: ☐ Numbness ☐ Tingling ☐ Weakness

Does your pain change when you cough or sneeze?: ☐ Yes ☐ No

Does it travel into your arms and legs?: ☐ Yes ☐ No

Have you had any change in bowel or bladder function?: ☐ Yes ☐ No

Weight Change?: ☐ Yes ☐ No

Do you take prescribed medications? (Please List): ____

____

Do you take any over-the-counter medicines? If it is for your pain, does it help? (Please List): ____________________

____

Have you had any serious injuries to your head, neck or back? (Please List): ___________________________________

____

Have you had any surgeries, fractures or hospitalizations? (Please List): ______________________________________

____

Have you been diagnosed with any chronic illnesses (i.e. high blood pressure, cancer, heart disease, diabetes, stroke)? (Please List): ____

____

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Do you have a primary care provider (Family Physician)?: ☐ Yes ☐ No Who?: ______________________________

When was your last physical exam?:______________________ Any significant findings?:______________________

____

Is your stress level high: ☐ Yes ☐ No

Have you had any X-ray, CAT, or MRI exams in the last 5 years?: ☐ Yes ☐ No Date: _________________________

If yes, what body regions?: ____

Do you have surgical implants (i.e. joint, pacemaker, IUD, breast, screws, plates, heart valve)?: ☐ Yes ☐ No

For Females (Women):

Is it possible your pregnant?: ☐ Yes ☐ No Last menstrual period: ______________________

Do you have any blood relatives/family history with the following?:

☐ Cancer ☐ Stroke ☐ Seizures ☐ Diabetes ☐ Other:____

What relationship/disorder?: ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Dominant Hand: ☐ Right ☐ Left

Do you smoke?: ☐ Yes ☐ No Do you have children?: ☐ Yes ☐ No How many?: _________Girls ________ Boys

Do you exercise?: ☐ Yes ☐ No How?:_________________________ How often?:________________________

What is your occupation/profession?: ____

Do you have hobbies?: ____

What are your goals of care?: ____

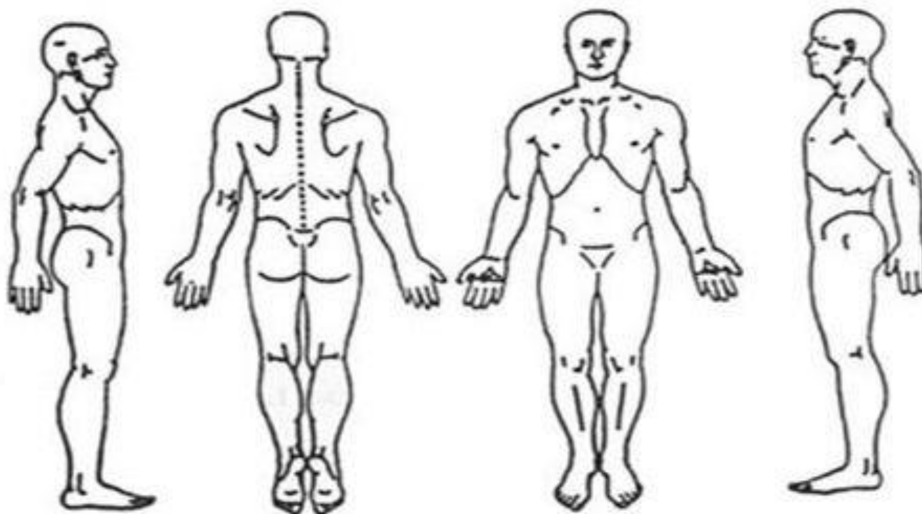
Please shade and use codes to indicate the location of your problem(s) on the diagrams below.

P = Pain

N = Numbness

S = Muscle Spasm

T = Tenderness



____ ____

Patient Signature Interviewer Signature (Office Use Only)