Bull Run Chiropractic Clinic
38916 Proctor Blvd
Sandy, OR 97055
(503) 668-3530

General Health History

Thank you taking the time to completely fill out this information. This helps us to better help you.

Name_____Birth Date_____Today's Date _____

Why are you seeking care today?_____

How long have you noticed this?_____

How did it start, any particular injury?_____

Have you noticed this in the past?_____Is your pain/ discomfort constant or does it come and go _____

Are your symptoms worse a certain time of day?_____

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

_____

Rate your pain 0-10 (if 0 = no pain, 10 = worst pain you can imagine) _____out of 10

Do you experience headaches? Yes/ No How often?_____per_____How long do they last?_____

What makes your pain worse? Name three things:1_____2_____3_____

What helps make your pain better if any thing?_____

Have you experienced any? Numbness No Tingling No Weakness No

Does your pain change when you cough or sneeze? No Does it travel into arms/ legs? No

Have you had any change in your bowel or bladder function? No Weight change? No

Do you take prescribed medications? (please list)_____

_____

Do you take any over-the-counter medicines? If for pain does it help?(please list)_____

_____

Have you had any serious injuries to your head, neck or back? (please list)_____

_____

Have you had and surgeries, fractures or hospitalizations? (please list) _____

_____

Have you been diagnosed with any chronic illnesses (ie. high blood pressure, cancer, heart disease, diabetes, stroke)? Please list_____

_____

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Name:_____Date:_____

Do you have a primary care provider (family physician)? No (who)_____

When was your last physical exam_____Any significant findings?_____

_____Is your stress level high? No

Have you had any X-ray, CAT or MRI examinations in the last 5 years? No Date _____

If yes, of what body regions?_____

Do you have surgical implants (ie. joint, pacemaker, IUD, breast, screws, plates, heart valve)? No

For Women: Is it possible you are pregnant? No Last menstrual period: _____

Do you have any blood relatives with _____cancer ☐ stroke ☐ seizures ☐ diabetes ☐ other_____

What relationship/ disorder _____

Marital status: S ☐ M ☐ D ☐ W ☐ Dominant hand: Right ☐ Left ☐ Do you smoke? Yes ☐ No ☐

Do you have children? No Number of children: _____Girls_____ Boys

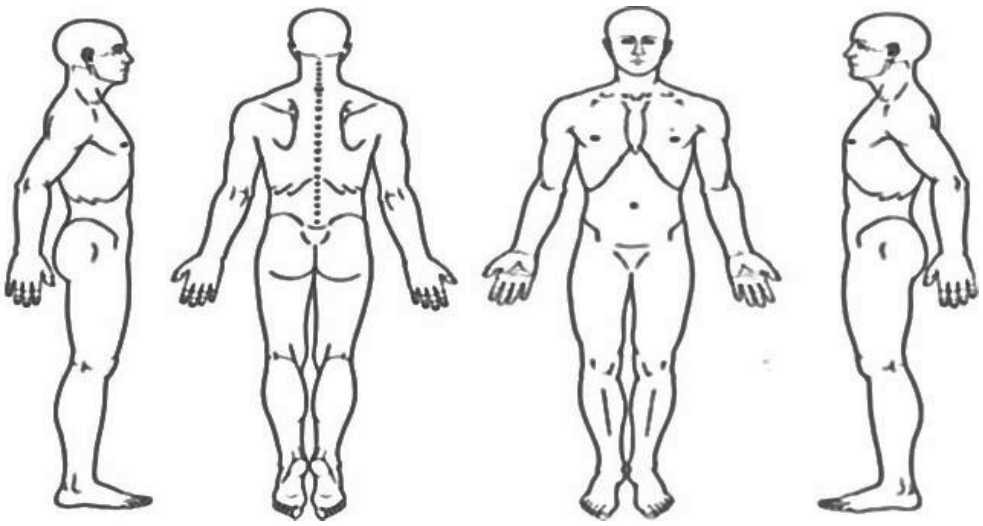
Do you regularly exercise? No How?_____ How often?_____

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