STEFFEN CHIROPRACTIC CENTER
500 HIGHWAY 96 WEST #150
SHOREVIEW, MN 55126

MEDICAL HISTORY FORM

Name _____ Date_____

Address_____ Date of Birth_____

City _____State _____ Zip _____S.S.#/Medicare Number_____

Home Phone_____ Cell Phone _____

Cell Phone Carrier _____ Email Address _____

Occupation _____Work Phone _____

Preference for appointment reminders: ___Text ___Email ___Home Ph. ___Work Ph.

Gender: M or F Married: Y N Spouse's Name_____

Emergency Contact Name_____ Phone # _____

Address _____ City _____State _____ Zip _____

Medical Doctor Name _____ Phone # _____

May we send your Family Physician updates on your progress Yes_____ No _____

MAIN PROBLEM

What pain causes you to come to the office? _____

Is this Work Compensation? Yes _____ No _____ Is this an Auto Accident? Yes _____ No _____

What caused this pain? _____

When did this pain start? _____How long does this pain last? _____

How bad is this pain? (circle the one that applies) Mild Moderate Severe Intolerable

Circle the word or words that best describe the pain: Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lightening, Throbbing, Nagging, Burning, Deep, Stinging, Pressure

How often does the pain occur? (circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? _____

What makes this pain better? _____Worse? _____

What else have you done to treat this pain? _____

List previous Doctors, Therapists you have seen for this problem_____

OTHER PROBLEM

What other pain do you have? _____

What caused this pain? _____

When did this pain start? _____ How long does this pain last? _____

How bad is this pain? (circle the one that applies) Mild Moderate Severe Intolerable

Circle the word or words that best describe the pain: Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lightening, Throbbing, Nagging, Burning, Deep, Stringing, Pressure

How often does the pain occur? (circle the ones that apply) Occasional, Frequent, Constant

Does this pain travel to any other area? _____

What makes this pain better? _____Worse? _____

What else have you done to treat this pain? _____

Family History

Please tell us about the health of your parents, siblings, and children. Circle or check everything that applies. If someone is deceased, please check or write in the cause.

FAMILY	LIVING/DECEASED CAUSE	HEART DISEASE	STROKE	CANCER	DIABETES	RHEUMATOID ARTHRITIS	MULTIPLE SCLEROSIS	LUNG DISEASE	BONE DISEASE
FATHER	L D CAUSE								
MOTHER	L D CAUSE								
SIBLING CHILD	L D CAUSE								
SIBLING CHILD	L D CAUSE								
SIBLING CHILD	L D CAUSE								

Past and Social History

If working, name of employer _____ How is your health? _____

Do you drink alcohol? Y N Use tobacco? Y N Use recreational drugs? Y N

Caffeine: Y N if yes, 3 cups daily, 3-6 cups daily, more than 6 cups daily

Exercise: (circle one) Never Daily Weekly --- (type) Walk, Run, Swims, Lift Weights, Other _____

Have you had any illnesses in the past? _____

Have you had any injuries? Y N (if so, type and year) _____

Have you been hospitalized? Y N (if so, for what and year) _____

Have you had any surgeries? Y N (if so, what & year) _____

List any medications that you are currently taking _____

I certify that the information that I have given here is true and accurate to the best of my knowledge.

_____

Signature **Date**

How were you referred to us: (circle all that apply) Family Member Friend Work Internet (if so, which one?) _____