



PERFORMANCE & HEALING CHIROPRACTIC

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PATIENT HISTORY

Dear Patient: The completion of this form is a sensible first step prior to experiencing the many benefits associated with chiropractic care. This form has been designed to assist with delivering the most appropriate chiropractic care and/or identifying any possible risk factors to your health and safety to provide appropriate care and advice. Please provide the answers that represent your case to the best of your knowledge as your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

NAME _____ DATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ WORK PHONE _____

DATE OF BIRTH (MM/DD/YYYY) ___/___/___ AGE ___ M F MARITAL STATUS _____ NO. OF CHILDREN _____ FAX # _____

OCCUPATION _____ SSN# _____ SPOUSE: _____ E-MAIL: _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ REFERRED BY _____

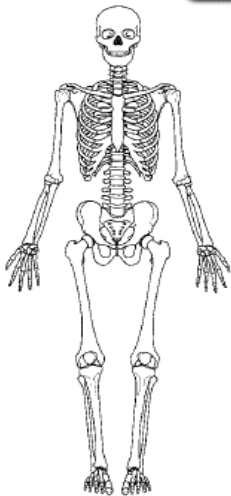
IN CASE OF EMERGENCY (Name of relatives or close friend not living in your home):

NAME: _____ ADDRESS: _____ PHONE _____

Please label the area of complaint with the following numbers:

1 = Dull 2 = Throbbing 3 = Muscle tightness 4 = Numbness 5 = Sharp * = Other: _____

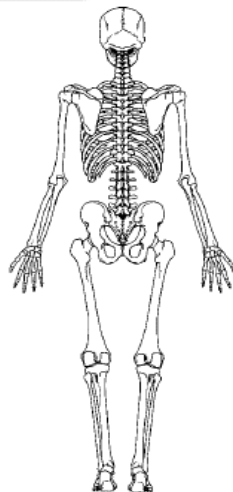
Mark Areas of Complaint



Anterior Skeleton



Lateral Skeleton



Posterior Skeleton

What is your major complaint? _____

Other complaints _____

Have you ever had previous chiropractic care? _____ If yes, date of last care _____

Do you have Health and Accident Insurance? _____ If yes, with what company? _____

Regarding your current condition:

How long have you had this condition? _____ Have you had this or similar condition in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily routine Other _____

List previous diagnoses and treatments you have received for present condition _____

What do you believe is wrong with you? _____

Are you on any medications? Yes No Please List: _____

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Used a cane, crutch, or other support?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized for other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a motor vehicle accident or serious injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had any X-rays, CT scans, MRI, Ultrasound?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had any unexplained weight loss?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had any recent changes in a mole or freckle?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had any unusual lumps or swellings?	<input type="checkbox"/>	<input type="checkbox"/>	_____

DO YOU:			
Now take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have an allergy to any drug?	<input type="checkbox"/>	<input type="checkbox"/>	_____

HABITS	Heavy	Moderate	Light	Past Use	None	LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE PAST 10 YEARS
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Below are items that may seem unrelated to the purpose of your appointment. However, please answer these items carefully as they can affect your overall course of chiropractic care. Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. REST ASSURED THAT THIS IS A CONFIDENTIAL HEALTH REPORT.

			O – Occasional				F – Frequent				C – Constant
O	F	C	GENERAL	O	F	C	GASTRO-INTESTINAL	O	F	C	GENITO-URINARY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine/Stool
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inability to control bladder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection or stones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal worms				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice				O F C FOR WOMEN ONLY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congested breast
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness/depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive menstrual flow
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycle
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting of blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal menstruation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge
				O	F	C	CARDIO-VASCULAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?
O	F	C	MUSCLE & JOINT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hardening of arteries				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	O	F	C	EYES, EARS, NOSE, THROAT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deafness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain or stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental decay
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain between shoulders					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor posture	O	F	C	RESPIRATORY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear noise
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged thyroid
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Spasms/Cramping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain
			<i>Pain or numbness in:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failing vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulders					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arms	O	F	C	SKIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elbows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal obstruction
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin eruptions (rash)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tail bone								

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD?

- | | | | |
|---|---|------------------------------------|-----------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> HIV/AIDS | Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Influenza | Rheumatic fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malaria | Scarlet fever |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fever blisters | Miscarriage | Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Goiter | Multiple sclerosis | Typhoid fever |
| <input type="checkbox"/> Chorea | <input type="checkbox"/> Gout | Mumps | Ulcers |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Heart attack | Pleurisy | Veneral disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease | Pneumonia | Whooping cough |

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

ANY ADDITIONAL INFORMATION THAT YOU FEEL WOULD BE HELPFUL IN DETERMINING YOUR CONDITION

CANCELLATIONS: We ask that you respect our cancellation policy to ensure we have enough time to contact other clients on our waiting list. 24 hours' notice is required for cancellation or re-scheduling. If notice is not received, a cancellation fee will be charged.