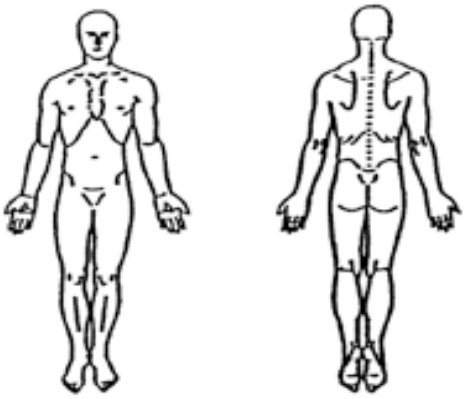
BOZEMAN WELLNESS CENTER

Chiropractic Applied Kinesiology Vitamins Herbs Homeopathy Health Education Classes

DEMOGRAPHIC UPDATE

Name_____ Date_____
Address _____
City_____ State_____ Zip _____
Home Phone _____Cell Phone # _____Work: _____
Email Address _____
Occupation _____ Employer_____
Age _____ Birth Date _____ Marital Status M S W D How many Children?_____
Emergency Contact Name: _____
Emergency Phone Number _____

Have you had any traumas or surgeries since your last appointment? Yes _____ No _____
If yes please mark on body (strains/sprains, broken bones, severe bruises, surgeries, scars, bumps, cuts, burns, etc.)



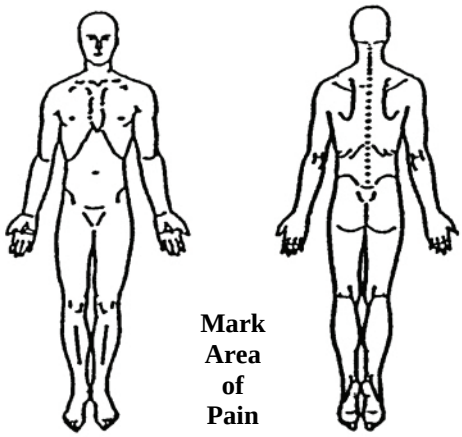
What happened? **When did it happen?**

FOR OFFICE USE – DO NOT FILL IN

MEDICAL HISTORY

PATIENT NAME:_____ **DATE:**_____

IF YOU ARE NOT IN PAIN, please list your current complaints below. **IF YOU ARE IN PAIN**, mark area of pain on diagram and describe.



Mark Area of Pain

When were you first aware of the problem(s)?								
What caused the problem(s)?	specific incident		multiple incidents		gradual onset		no reason	
Have you received treatment for the problem(s)?	yes	no	**If yes, where, when, results?**					
Have you previously experienced similar symptoms?	yes	no	**If yes, when ?**					
Were you treated previously for similar symptoms?	yes	no	**If yes, where, when, results?**					
Has/Have problem(s) been getting/staying	better	worse	same	**Comments:**				
What makes your problem better?	nothing	lying down	walking	standing	sitting	movement	inactivity	food intake
What makes your problem worse?	nothing	lying down	walking	standing	sitting	movement	inactivity	food intake
How would you rate your level of stress?	no stress		minimal stress		moderate stress		severe stress	
Describe your physical activities at work:	sit 50+% of time		stand 50+% of time		light labor		heavy labor	
Describe your regular physical activity/exercise:	none		light		moderate		strenuous	
What aspects of your life have been affected?	home life		work life		recreation		rest / sleep	
Describe the affects on your life:								
Do you need assistance with everyday tasks?	yes	no	**Comments:**					
Do you need assistance often?	yes	no						
Can you function without assistance?	yes	no						
Do you have any physical restrictions?	yes	no						
Are you able to work?	yes	no						
Any accidents, injuries or illnesses NOT reported above?								
Are you pregnant?	yes	no	**Date of last menstrual period:**					
CURRENT DRUGS and PAST SURGERIES:								

HEAD - (CIRCLE AS MANY AS APPLY)

Lightheaded Fainting Loss Of Balance Memory Loss
Double Vision Blurred Vision Light Sensitivity Bloodshot Eyes
Hearing Loss Ringing In Ears Head Feels Heavy
HEADACHE: Migraine Tension Pressure Throbbing Sinus
Daily 1XWeek 2XWeek 3XWeek ___XWeek ___XMonth
Back Of Head Forehead Temples Behind Eyes All Over
My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

NECK - (CIRCLE AS MANY AS APPLY)

Pain Stiff Tight Tension Ache
Left Side Right Side Both Sides
Base of Skull Nape of Neck Entire Neck
Muscle Spasms Muscle Weakness Grinding/Grating
Aggravated by: Forward Movement Backward Movement
Rotate Left Rotate Right
Bend Left Bend Right
My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

SHOULDERS - (CIRCLE AS MANY AS APPLY)

Pain Across Shoulders	Left	Right	Both
Pain In Joint	Left	Right	Both
Limitation Of Motion	Left	Right	Both

My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

ARMS & HANDS - (CIRCLE AS MANY AS APPLY)

Pain In:	Upper Arm	Left	Right	Both
	Elbow	Left	Right	Both
	Forearm	Left	Right	Both
	Wrist	Left	Right	Both
	Hand	Left	Right	Both
Pins & Needles In:	Arm	Left	Right	Both
	Hand	Left	Right	Both
Numbness In:	Arm	Left	Right	Both
	Hand	Left	Right	Both

My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

MID BACK - (CIRCLE AS MANY AS APPLY)

Pain	Left	Right	Center
Spasms	Left	Right	Center
Tension	Left	Right	Center

My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

CHEST - (CIRCLE AS MANY AS APPLY)

Pain Between Ribs	Left	Right	Both
Pain in Breast Bone	Left	Right	Both

Shortness Of Breath Irregular Heartbeat
My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

ABDOMEN - (CIRCLE AS MANY AS APPLY)

Constipation Indigestion Nausea
Diarrhea Heartburn Gas
Loss Of Appetite Nervous Stomach Pain
My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

LOW BACK - (CIRCLE AS MANY AS APPLY)

Low Back Pain	Left	Right	Both
Sacroiliac Pain	Left	Right	Both
Buttock Pain	Left	Right	Both
Hip Pain	Left	Right	Both

My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

LEGS & FEET - (CIRCLE AS MANY AS APPLY)

Pain Radiates Down Leg to:	Mid-Thigh	Left	Right	Both
	Knee	Left	Right	Both
	Calf	Left	Right	Both
	Foot	Left	Right	Both
Pins & Needles In:	Leg	Left	Right	Both
	Foot	Left	Right	Both
Numbness In:	Leg	Left	Right	Both
	Foot	Left	Right	Both

Ankle Pain Swollen Ankle Foot Pain Swollen Feet Cramps
My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Dull Sharp Burn Throb Pain Scale 0-10:___

OTHER - (CIRCLE AS MANY AS APPLY)

Anxiety Nervousness Irritability Apprehension
Disturbed Sleep Fatigue Depression Inability to Concentrate
Jaw Pain Hemorrhoids Ulcers Cancre Sores
Frequent Urination Painful Urination Incontinence
Difficulty Starting Urinary Flow Difficulty Holding Urine
Heart Trouble Recurrent Infections Prostate Trouble
Menstrual Pain Menstrual Irregularity Hot Flashes PMS
Frequent Colds Asthma Allergies Chronic Cough
Weight Loss Weight Gain Hypoglycemia Diabetes
My Symptoms Are: Constant Frequent Intermittent Occasional
Mild Moderate Severe Comments:_____

CHECK ANY of the following conditions YOU NOW HAVE

METABOLIC
- ____ Heart Disease
- ____ Cancer
- ____ Stroke
- ____ Arthritis
- ____ Neuritis
- ____ Colitis

DIGESTIVE
- ____ Irritable Bowel
- ____ Belching
- ____ Flatulence
- ____ Vomiting
- ____ Blood in Stool
- ____ Food Sensitivities

EYES - EARS - NOSE - THROAT
- ____ Glasses
- ____ Floaters
- ____ Loud Noise Intolerable
- ____ Dry Nasal Membranes
- ____ Excess Mucous
- ____ Hoarseness

OTHER:_____

_____

I understand that the information provided above will assist the doctor in making clincal decisions and acknowledge that these records and any tests performed, including x-rays, will remain a part of my permanent record. I have answered every question fully and completely.

SIGNATURE of PATIENT/GUARDIAN_____