✦ Holistic Health Clinic ✦ 12320 SW Allen Blvd.✦ Beaverton, OR 97005 ✦ (503) 646-8575 ✦
Marcella L. Box, D.C. James A. Cruz, D.C.

CONFIDENTIAL PATIENT INFORMATION/ MAJOR MEDICAL

Name ______________________________ **S.S.N.**____________________ **Date** _______________

Address __________________________________ **City/State** _________________ **ZIP** __________

D.O.B ____________ **Height/Weight** _________________ **Home Phone** _______________________

Employer ___________________ **Occupation** ______________ **Work Phone** ___________________

Message phone or Cell Phone ______________________ **Spouse/Partner Name** _________________

Whom may we thank for referring you to us ____

Emergency Contact _________________________ **ER Contact Phone #** ______________________

Purpose for visit ____ **Date of onset** ________________

Symptoms developed from: Work Injury ____ **Auto Accident** ____ **Other** ______________________

Have you ever had similar symptoms? (dates) ____

Have you ever had pain in other areas of your spine? (dates) _______________________________

Dates of previous auto accidents ____

List surgical operations w/ dates ____

List any medications you are on ____

Other doctors consulted for this condition? (dates) ____

Do you have a past history of injuries involving: (dates) ankles _______ **knees** _____

hips _________ **wrists** _________ **elbows** _________ **shoulders** _________

Have you had X-Rays taken of your spine in the last 7 years? ________________________________

<u>Family History:</u> **(List any significant diseases, i.e.: diabetes, cancer, etc.) Are you adopted?** ______

Mother_________________________________ **Father** __________________________________

Grandparents _________________________ **Aunt/Uncle/Siblings** _________________________

Dates of last physical exam _________ Any unusual findings _________________________________

Do you exercise regularly? ________ Types and How often? _________________________________

<u>Men</u>: Date of last prostate exam ________________ Date of last colon exam ___________________

Any unusual Findings____

<u>Women:</u> Date of last pap smear __________________ Date of last mammogram _______________

Any unusual findings ____

Are you pregnant? ________ Due Date _______________ Trying to get pregnant? _______________

Do you have children? ___________________ How many? __________________________________

Do you have breast implants? _____________ Date implanted ________________________________

Chief Complaint ____

ONSET (what were you doing when injury occurred) _____________________________________

PROVOKING (what activities aggravate your injury) Circle- **Sitting / Standing / Lying / Walking / Reaching/ Bending / Other ___________________________**

PALLIATIVE (what makes it feel better) Circle- **Ice / Heat / Lying / Pain Med. / Stretching / Other ____**

QUALITY (describe the pain) Circle- **Sharp / Electric / Burning / Stabbing / Aching / Deep / Other ____**

Any sensations radiating into the following -Circle- **Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades / Other __________________________________**

Describe the radiating -Circle- **Sharp / Dull / Tingling / Numbness / Prickling / Other ______________**

SEVERITY On a scale of 0-10 with 0 being no pain and 10 pain prevents ALL activities _________

PATTERN (time of day most aggravated) Circle- **Early Morning / Mid Day / Late Eve / After Work / After Exercise / Other ____**

CHECK ANY OF THE FOLLOWING YOU ARE CURRENTLY EXPERIENCING

HEAD

_______ **Headache**
_______ **Allergies**
_______ **Dizziness**
_______ **Deafness**
_______ **Ringing in Ears**
_______ **Loss of Balance**
_______ **Fainting**
_______ **Eye Pain**
_______ **Failing Vision**
_______ **Nosebleeds**
_______ **Sinus Infection**

CHEST

_______ **Chest Pain**
_______ **Difficulty Breathing**
_______ **Asthma**

ABDOMEN

_______ **Difficult Digestion**
_______ **Abdominal Cramps**
_______ **Diarrhea**
_______ **Constipation**
_______ **Nausea**
_______ **Change in Urinary Function**
_______ **Change in Bowel Function**

OTHER

_______ **Loss of Sleep**
_______ **Nervousness**
_______ **Depression**
_______ **Fever**
_______ **HIV+/Aids**
_______ **Change in Menstrual Cycle**
_______ **Pregnant**
_______ **Hemorrhoids**
_______ **Other**____________________

PLEASE GIVE DATES FOR ANY OF THE FOLLOWING YOU'VE HAD

_______ **Alcoholism**
_______ **Appendectomy**
_______ **Cancer**
_______ **Diphtheria**
_______ **Gall Bladder Problems**
_______ **Heart Disease**
_______ **Liver Problems**
_______ **Multiple Sclerosis**
_______ **Polio**
_______**Thyroid Trouble**
_______ **Venereal Disease**
_______ **Allergies**
_______ **Arteriosclerosis**
_______ **Colitis**
_______ **Eczema**
_______ **Goiter**
_______ **Hepatitis**
_______ **Malaria**
_______ **Pleurisy**
_______ **Prostate Problems**
_______ **Tuberculosis**
_______ **Whooping Cough**
______ **Anemia**
______ **Arthritis**
______ **Diabetes**
______ **Emphysema**
______ **Epilepsy**
______ **Kidney Stone/ Infection**
______ **Migraines**
______ **Pneumonia**
______ **Scarlet Fever**
______ **Ulcers**

Signature _____________________________________ **Date** ____________________________

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