

**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 Yes/ No,      Tingling Yes/ No,      Weakness Yes/ No

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

Have you had any change in your bowel or bladder function? Yes/ No      Weight change? Yes/ 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 \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Do you have a primary care provider (family physician)? Yes/ No (who) \_\_\_\_\_

When was your last physical exam \_\_\_\_\_ Any significant findings? \_\_\_\_\_

\_\_\_\_\_ Is your stress level high? Yes/ No

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

If yes, of what body regions? \_\_\_\_\_

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

For Women: Is it possible you are pregnant? Yes/ 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: \_\_\_\_\_ Left \_\_\_\_\_ Right

Do you have children? Yes/ No Number of children: \_\_\_\_\_ Girls \_\_\_\_\_ Boys

Do you regularly exercise? Yes/ No How? \_\_\_\_\_ How often? \_\_\_\_\_

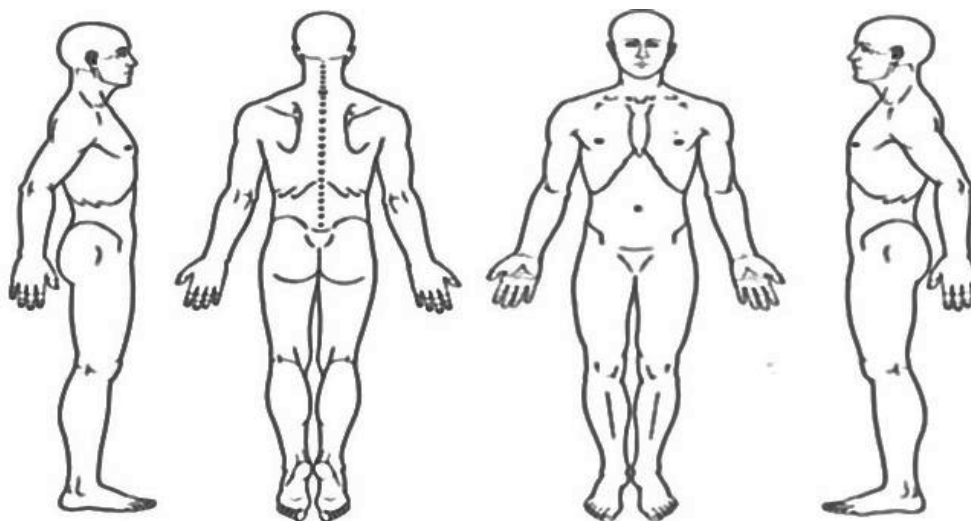
What is your occupation/ profession? \_\_\_\_\_

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