CHIROPRACTIC ASSOCIATES OF PITTSBURGH
1310 FREEPORT ROAD
PITTSBURGH, PA 15238
412-963-7400

PATIENT HISTORY

Date of Birth _____ Social Security Number _____-_____-_____
Last Name _____ First Name _____ Middle I. _____
Street Address _____ Apt # _____
City _____ State_____ Zip _____
Phone (H) _____ (W) _____ (Cell) _____
E-mail address _____
Spouse's Name _____
Your Occupation _____ Employer _____
Employer Address _____
Insurance Company _____ Policy Number _____

Have you been to another doctor for this problem? Y N Who? _____
What types of treatment or drugs were prescribed? _____
Did the previous treatments help? _____
Who referred you to our office? _____

WHAT BRINGS YOU TO OUR OFFICE?

Please indicate the main problem for which you are seeking help: _____
_____

- How long have you had this problem? _____ Onset? ____Gradual ____Sudden
- Do you know what caused it? Please describe _____
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____Ache _____ Burning _____Throbbing
- Does the Pain Radiate into your _____ Arm _____ Leg _____ Does not radiate
- Do you experience Numbness or Tingling? _____Yes _____No
- How often do you experience these symptoms?
  _____100% _____75% _____50% _____25% _____10%

****

Do you experience pain every day? ____Yes ____No
Do your symptoms interfere with daily life? ____Yes ____No
Does pain wake you up at night? ____Yes ____No
Do changes in weather affect your symptoms? ____Yes ____No
Are your symptoms worse during certain times of the day? ___ Yes ___No If so, when? _____

Please list any other complaints you may have: _____
_____

PATIENT SIGNATURE _____DATE _____

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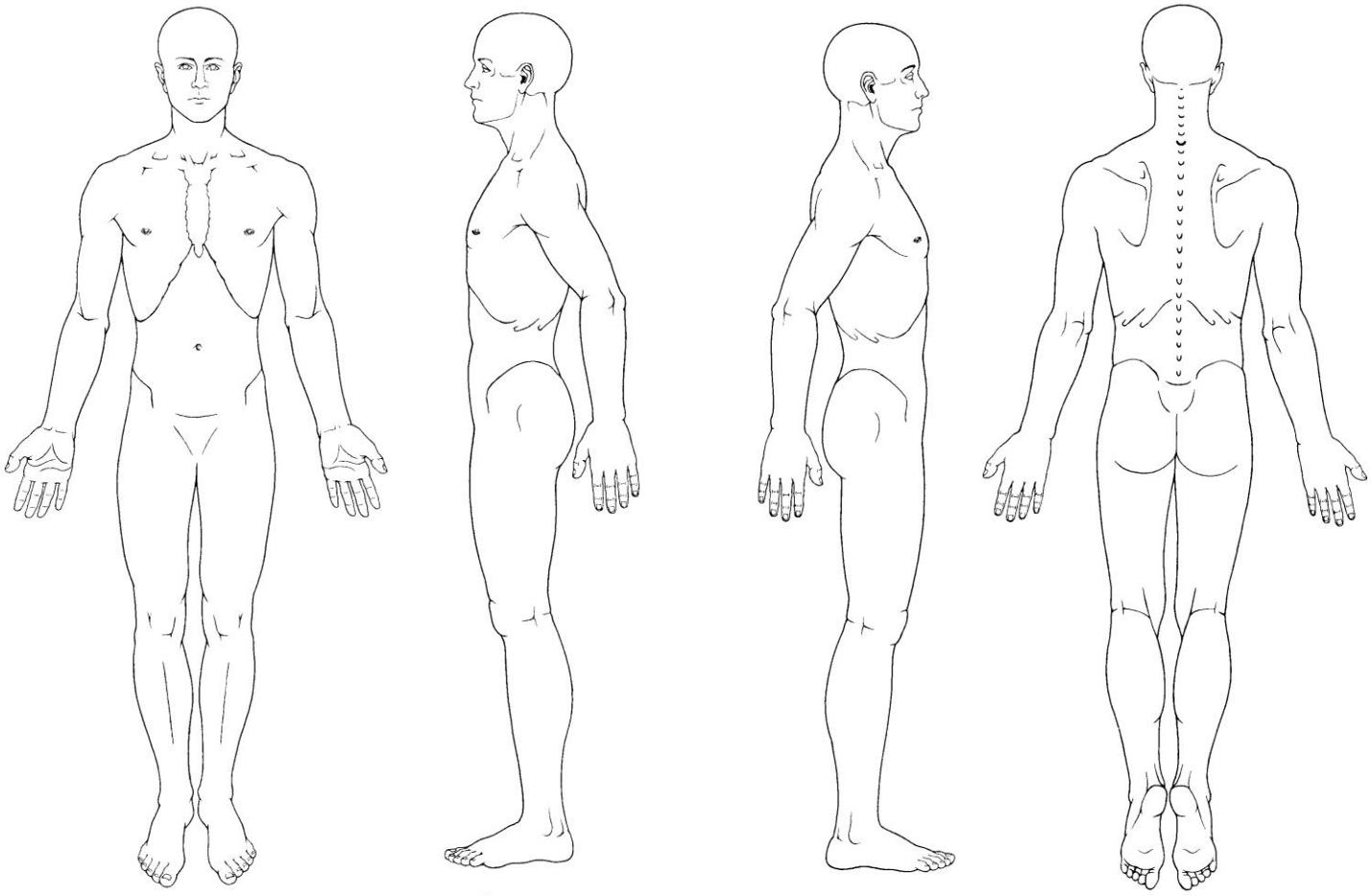
PATIENT HISTORY

PAIN LOCATION



Please mark off the areas of your complaints on the diagrams above. Please use the following symbols on the pain diagrams to accurately describe your conditions.

PPP	**Where you experience Pain**
NNN	**Where you experience Numbness**
TTT	**Where you experience Tingling**
BBB	**Where you experience Burning**
CCC	**Where you experience Cramping**

PATIENT SIGNATURE _____DATE _____

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PATIENT HISTORY

Have you been treated for any health conditions in the past year? _____Yes _____No
If yes, please describe _____

Is there a chance that you are currently pregnant? ___Yes ___No

Have you ever been under chiropractic care? ___Yes ___No If yes, when? _____

Please circle response and elaborate:

Do you smoke or use tobacco products? Yes No _____
Do you have Diabetes? Yes No _____
Have you ever had a stroke? Yes No _____
Do you currently have or have you ever had cancer? Yes No _____
_____

Have you been diagnosed with any other major health condition? Yes No _____

Have you ever been involved in any auto accidents or had any other injuries, falls or accidents? Please list:

What _____ When _____
What _____ When _____
What _____ When _____

Please list all past surgeries:

Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____

Additional Comments or any other information you feel may be pertinent to your condition:
_____
_____
_____
_____

PATIENT SIGNATURE _____DATE _____

REVIEW OF SYSTEMS:

NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

REVIEWED BY: _____

GENERAL, CONSTITUTIONAL
Recent weight loss.....[No][Yes]
Fever.....[No][Yes]
Chills.....[No][Yes]

EYES, VISION
Visual Changes.....[No][Yes]

EARS, NOSE, THROAT
Hearing loss.....[No][Yes]
Sinus problems.....[No][Yes]

HEART, CARDIOVASCULAR
Chest pain or pressure.....[No][Yes]
Arrythmia or palpitations.....[No][Yes]
Shortness of breath.....[No][Yes]
Peripheral edema.....[No][Yes]
Blood clots.....[No][Yes]
Varicose Veins.....[No][Yes]
Cramping in thighs.....[No][Yes]

RESPIRATORY
Cough.....[No][Yes]
Shortness of breath.....[No][Yes]
Wheezing.....[No][Yes]

GASTROINTESTINAL
Abdominal pain.....[No][Yes]
Heartburn.....[No][Yes]
Bloody stool.....[No][Yes]

GENITOURINARY
Frequent urination.....[No][Yes]
Urgency.....[No][Yes]

MUSCULOSKELETAL
Joint pain or swelling.....[No][Yes]
Restricted motion.....[No][Yes]
Musculoskeletal pain.....[No][Yes]

SKIN & INTEGUMENTARY
Rashes.....[No][Yes]
Sores.....[No][Yes]
Growths.....[No][Yes]

NEUROLOGICAL
Numbness or tingling sensations.....[No][Yes]
Sensation loss.....[No][Yes]
Burning .....[No][Yes]

PSYCHIATRIC
Nervousness, anxiety.....[No][Yes]
Depression.....[No][Yes]

ENDOCRINE
Heat or cold intolerance.....[No][Yes]
Excessive thirst.....[No][Yes]

HEMATOLOGIC/ LYMPHATIC SYSTEM
Abnormal bleeding.....[No][Yes]
Swollen or tender lymph nodes.....[No][Yes]

ALLERGIES/ IMMUNE SYSTEM
Allergic reaction.....[No][Yes]
Recurrent infections.....[No][Yes]

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My Medication List

Your Name: _____ Date: _____

Prescription Medications

Please list the names and detailed information about your prescription medications.

Name of Medication	Why You Take It	Strength	How Much You Take	How Often You Take It	Name of Doctor Who Prescribed It	Where You Get Your Medications
Example: Lipitor (Atorvastatin)	For High Cholesterol	20 mg	1 pill	Daily (every morning)	Dr. Greg Wilson	Local Pharmacy, (555) 123-4567

Medicines You Buy Over the Counter

Include things like pain medicine, herbal supplements, and vitamins.

Name of Medicine	Why You Take It	How Often

Allergic Reactions

List any allergic reactions you've had to medications in the past.

Name of Medication	Describe the Reaction You Had

To get a copy of this form, go to: www.my-emmi.com/emmiassets/forms/fm_med_hist_patient_lp.html