Stitt Chiropractic
Patient History

Reason for your visit_____

Is the purpose of your visit related to: ☐ Job ☐ Sports ☐ Fall ☐ Auto Accident ☐ Home Injury ☐ Chronic Discomfort ☐ Other

Please explain _____

If job related, have you made a report of your accident to your employer? ☐ Yes ☐ No

When did this condition begin?_____ _____

Has this condition: ☐ Gotten worse ☐ Stayed constant ☐ Comes and goes

Does this condition interfere with: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other activities

Please explain_____

Has this condition occurred before? ☐ Yes ☐ No

Please explain_____

Have you seen other doctors for this condition? ☐ Yes ☐ No Doctor's Name_____

Results_____ Approx. Date of last visit_____

Have you ever had a serious medical problem? ☐ Yes ☐ No_____

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No_____

Have you ever had a serious injury? ☐ Yes ☐ No _____

Are you currently taking any medications? ☐ Yes ☐No _____

If a woman, are you currently pregnant? ☐ Yes ☐ No Date of last period_____

Please check any conditions you have now or have had in the past:

☐ Severe or frequent headaches
☐ Kidney problems
☐ Sinus problems
☐ Shingles
☐ Ulcers/colitis
☐ Asthma
☐ Loss of sleep
☐ Pain between shoulders

☐ High/low blood pressure
☐ Difficulty breathing
☐ Frequent neck pain
☐ Numbness
☐ Frequent colds
☐ Arthritis
☐ Dizziness
☐ Heat attack/stroke

☐ Congenital heart problem
☐ Digestive problems
☐ Problems with depression
☐ Pain in arms/legs/hands/wrist
☐ Lower back problems
☐ Constipation/diarrhea
☐ Menstrual problems
☐ Bladder problems

I guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in completion of this form.

Patient Signature_____ Date_____ 01/07