**Integrity Chiropractic | 11319 NE 120th Street, Kirkland, WA 98034 | 425-298-0665**

# DEMOGRAPHIC & MEDICAL HISTORY FORM

**(FORM UPDATED 05/23/2020)**

Patient Name: _____ Date of Birth: _____Today's Date: _____

Address: _____

Phone #: _____ Email: _____ Occupation: _____

Emergency Contact Name & Phone #: _____

How Did You Hear About Us? _____

## PATIENT MEDICAL HISTORY

**We will discuss the reason for your visit in the interview. PLEASE INDICATE ANY MEDICAL CONDITIONS OR PROBLEMS AS THEY MAY AFFECT YOUR TREATMENT. We will have you update this form on a yearly basis. Please update any changes in your medical history at that time.**

☐ **Existing Patients: Check here for no changes in medical history in the past year. If there are, simply note the changes. We keep this in your file.**

### General

- ☐ Recent weight gain; how much _____
- ☐ Recent weight loss; how much _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

### Musculoskeletal

- ☐ Bone Disease / Cancer of Bone
- ☐ Neck / Back / Spine Problems
- ☐ Sprain/Strains
- ☐ Tendonitis / Bursitis
- ☐ Fibromyalgia
- ☐ Jaw Pain (TMJ)
- ☐ Recent (1 yr.) Fracture
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Carpal Tunnel Syndrome
- ☐ Joint Disease (Arthritis / Osteoarthritis / Rheumatoid Arthritis / Gout / Hypermobility)
- ☐ Other: _____

### Cardiovascular

- ☐ Heart Condition: _____
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Fainting
- ☐ Cough
- ☐ Emphysema / COPD
- ☐ Phlebitis / Deep Vein Thrombosis / Blood Clots / Embolism / Varicose Veins
- ☐ Abnormal Blood Pressure, Specify: _____ _____
- ☐ Easy Bruising
- ☐ Atherosclerosis / Arteriosclerosis
- ☐ Swollen Glands
- ☐ Lymphoma
- ☐ Lymphedema
- ☐ Other:_____

### Endocrine

- ☐ Intolerance to heat / cold
- ☐ Excessive Thirst
- ☐ Hypothyroidism / Hashimoto's
- ☐ Hyperthyroidism / Grave's

### GI

- ☐ Nausea
- ☐ Heart Burn
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Yellow Jaundice
- ☐ Increasing Constipation
- ☐ Persistent Diarrhea
- ☐ Blood in Stools
- ☐ Black Stools

### Skin

- ☐ Contagious Skin Condition
- ☐ Skin Cancer
- ☐ Open Sore or Wounds
- ☐ Easy Bruising
- ☐ Rash / Eczema / Atopic Dermatitis / Allergies: _____

### Neurological

- ☐ Epilepsy
- ☐ Stroke
- ☐ Decreased Sensation / Numbness / Tingling / Weakness
- ☐ Other: _____

### Other

- ☐ Alcohol / Drug Abuse
- ☐ Diabetes
- ☐ Headaches/Migraines
- ☐ Current Fever
- ☐ Cancer: _____
- ☐ Artificial Joints: _____

**Continued on to back** 

## Women Specific Only

- ☐ Abnormal Pap Smear
- ☐ Irregular Periods
- ☐ Bleeding between periods

Are you trying to get pregnant? Y / N
Are you pregnant? Y / N, if yes, how far along are you? _____
Have you reached Menopause? Y / N. What Age? _____

## Any Recent Accidents / Injuries (What & Date):

_____
_____

## Smoking

Do you currently smoke or have you smoked? **Yes / No**
If yes, please specify the details below (i.e. 10 years, 1 pack/wk.):

_____

## Drinking

Do you drink alcohol? **Yes / No**
If yes, how often and how much (i.e. 2 glasses of wine/week):

_____

## Medications

Please list any medications that you are currently taking along with indication:

_____
_____

## Allergies

Please specify any allergies you may have:

_____
_____

## Anything else in your medical history we should know?

_____

## General Questions

- Please describe the physical nature of your work or duties (i.e. standing for several hours looking down):

  _____
  _____

- List any hobbies or sports you participate in on a regular basis:

  _____

Printed Name of Patient: _____

Signature of Patient: _____ Date: _____