

Pat Dougherty, D.C.
Chiropractic Lifecenter, Inc. @ North Central Chiropractic
2110 N. Washington, Spokane WA 99205
509 327 4373, (fax) 509 327 1244

ENTRY HISTORY

Patient Name: _____ Date: _____

Chief Complaint: _____

Other Symptoms (circle): Neck Pain Back Pain Headache Shoulder Pain Dizziness

Visual Changes Numbness tingling weakness, pain in Arms _____, Legs _____ :

Other _____ Have your bowel or bladder habits changed since your injury?

Is your pain: Constant ____, intermittent ____, dull ____, sharp ____, local ____, radiating ____, vague ____

Date pain began: _____ Immediate onset ____ Gradual onset ____

How did it start? _____

Have you had pain like this before? ____ When? _____

Is this condition interfering with your: work ____ sleep ____ daily routine ____ sports/exercise ____

Other _____ ; Job description _____, Do you like your job? ____

What have you done for this condition, did it work? _____

What other doctors have you seen for this condition? _____

Have you seen a chiropractor before? ____ : Did they focus on the neck and back pain? ____ ; or, also on overall health as the underlying cause of your problem? ____ ; Date of last treatment _____

Previous surgery and fractures _____

Previous auto accidents, injuries to the spine and loss of consciousness _____

Please list any diagnosed conditions or diseases you have had _____

Please list recent xrays, MRI, and other diagnostic tests _____

Allergies (include foods and medications) _____

Have you ever had a whole lot of vaccinations at one time? _____, When? _____

What medications are you currently taking _____

Have taken in the past six months _____

NAME:

DATE:

What supplements are you currently taking _____

How much time do you spend in front of a computer _____ , TV _____, Cell Phone use _____ .

Do you have trouble getting to sleep at night _____ Sleeping through the night _____

How much do you sleep on your back? _____ , belly _____ , right side _____ , left side _____

Do you have children? _____ , How many? _____, C-section _____ , vaginal birth _____ .

Was your birth natural _____ Premature _____ C-section _____ Forceps _____ Weight _____

Have you ever had & when: Blood Transfusions _____ Tonsillectomy _____ Seizures _____

Wisdom teeth removed _____ Gall Bladder removal _____ Appendectomy _____

List your scars _____

Are you perimenopausal? _____ Are you post menopausal? _____ Is your period regular _____

How often do you have a bowel movement _____ , Is urination painful or difficult _____

How much water do you drink/day _____ , Coffee & tea _____ , caffeinated? _____

Do you add anything? What? _____ ; soda pop _____, diet or regular (circle)

How often do you drink alcohol _____ Do you use tobacco? _____ , what kind _____

What foods do you crave _____ Do you have a sweet tooth _____

What foods do you eat regularly? _____

Do you eat fast foods _____ , other junk foods _____ , How often do you eat _____ , Do you diet? _____

Describe your energy level _____

On a 1-10 scale (10 being the highest) rate your level of: energy _____ , nutrition _____ ,

exercise _____ , what kinds of exercise do you do? _____

stress _____ , what are the biggest stresses in your life? _____

Are you healthier now than you were 5 years ago? _____ , Are you less healthy than 5 years ago? _____

How did you improve your health _____ ,

or why did your health decline? _____

Please write the health goals you hope to reach with treatment: _____

What would you like your health to be like 5 years from now? _____