Livingston Chiropractic Clinic
5889 Whitmore Lake Road, Suite 3 ~ Brighton, MI 48116
Phone: 810-227-7799 Fax: 810-227-8999

INITIAL VISIT - PATIENT HISTORY

Patient _____ **Date** _____

Main Area of Complaint:
☐ Head ☐ Neck ☐ Left Shoulder ☐ Right Shoulder
☐ Upper Back ☐ Mid Back ☐ Low Back
☐ Left Hip ☐ Right Hip ☐ Left Leg ☐ Right Leg/Foot
☐ Left Foot ☐ Right Foot ☐ Other: _____

Mechanism of Trauma:
☐ Auto Accident ☐ Employment Related Injury ☐ Activities of Daily Life
☐ Woke up this way ☐ Don't know - just happened ☐ Other _____

Description of Discomfort/Pain
Symptoms Began: ___/___/_____ Intensity: None **0 1 2 3 4 5 6 7 8 9 10** Worst
☐ Aching ☐ Dull pain ☐ Sharp pain ☐ Stabbing ☐ Numbness ☐ Tingling
☐ Loss of motion - Describe _____
☐ Migraine headache ☐ Sinus headache ☐ Stress headache

Discomfort/Pain is ☐ Constant ☐ Off and on ☐ Worse in morning ☐ Worse in evening

Aggravating Factors: ☐ Walking ☐ Standing ☐ Bending ☐ Sitting ☐ Lying down
☐ Get up from sitting ☐ Other _____

Alleviating Factors: ☐ Rx Medication/s _____ ☐ Daily ☐ Occasionally
☐ OTC Medications _____ ☐ Daily ☐ Occasionally
☐ Heat ☐ Cold / Ice ☐ Massage ☐ TENS ☐ Stretching / Yoga
☐ Other _____

Have you sought care for this complaint previously? ☐ No ☐ Yes, with _____

Other Areas of Discomfort/Pain
☐ Head ☐ Neck ☐ Left Shoulder ☐ Right Shoulder
☐ Upper Back ☐ Mid Back ☐ Low Back
☐ Left Hip ☐ Right Hip ☐ Left Leg ☐ Right Leg/Foot
☐ Left Foot ☐ Right Foot ☐ Other: _____

Affect on Activities of Daily Life

Personal Care	***Sleep***	***Walking***	***Sitting***	***Work / Chores***	***Social Life***
☐ Needs help	☐ Prevents sleep	☐ < 10 minutes	< 10 minutes	☐ Prevents	☐ Prevents
☐ Manages	☐ Interrupts sleep	☐ < 20 minutes	< 20 minutes	☐ Interferes	☐ Interferes
☐ No change	☐ No change	☐ No change	☐ No change	☐ No change	☐ No change

☐ Other _____

General Health History
Overall General Health ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
Please indicate if you (S), a parent (P), or another immediate family member (F) have a history of any of the following?

☐ Heart Condition:	*S*	*P*	*F*	☐ Diabetes:	*S*	*P*	*F*	☐ Arthritis:	*S*	*P*	*F*
☐ Kidney Disease:	*S*	*P*	*F*	☐ Cancer:	*S*	*P*	*F*	☐ Asthma:	*S*	*P*	*F*
☐ Sinus Problems:	*S*	*P*	*F*	☐ Insomnia:	*S*	*P*	*F*	☐ Dizziness:	*S*	*P*	*F*
☐ Digestive Issues:	*S*	*P*	*F*	☐ Headaches:	*S*	*P*	*F*	☐ Mental Health Problems:	*S*	*P*	*F*

Date of Last Physical Exam ___/___/_____ **Primary Doctor** _____

Do you take any prescription medications? No _____ Yes _____
If yes, please list _____

Do you use any supplements or Over-the-Counter medications? No _____ Yes _____
If yes, please list _____

Please list with year any surgeries/hospitalizations/serious illness _____

Signature _____ **Date** _____