Fey Chiropractic Thousand Oaks Spine & Injury Center
Chiropractic and Sports Medicine

PATIENT HISTORY

NAME ____ When did you first notice this problem ____/____/____

Height______'______" Weight______________ Age_____________ Sex ☐ Male ☐ Female

Have you ever seen a Chiropractor before? ☐ Yes ☐ No

Have you had: ☐ MRI ☐ X-RAY ☐ CT-SCAN ☐ Spinal Exam

What treatment have you received for this condition? ____

Name of the doctor(s) who have treated you for this condition ____

INJURIES/SURGERIES	DESCRIPTION	DATE
Accidents/ Falls	______________________________	__________
Head Injuries	______________________________	__________
Broken Bones	______________________________	__________
Dislocations	______________________________	__________
Surgeries	______________________________	__________

Have you been hospitized? If YES, why and when ____

SYMPTONS YOU CURRENTLY HAVE

☐ Headache	☐ Burning Eyes	☐ Loss of Memory	☐ Loss of Concentration
☐ Nausea	☐ Depression	☐ Lightheaded	☐ Ringing in Ears
☐ Vertigo	☐ Balance Impairment	☐ Loss of Memory	☐ Visual Disturbances

PAST OR PRESENTS SYMPTONS & CONDITIONS

☐ Aids/HIV	☐ Cataracts	☐ Herniated Disk	☐ Parkinson's Disease
☐ Anemia	☐ Chemical Depend	☐ Herpes	☐ Pinched Nerve
☐ Anorexia	☐ Diabetes	☐ High Blood Pressure	☐ Pneumonia
☐ Appendicitis	☐ Emphysema	☐ High Cholesterol	☐ Polio
☐ Arthritis	☐ Epilepsy	☐ Jaw Pain/TMJ	☐ Prosthesis
☐ Asthma	☐ Glaucoma	☐ Kidney Disease	☐ Psychiatric Care
☐ Blood Clots	☐ Goiter	☐ Liver Disease	☐ Rheumatoid Arthritis
☐ Breast Lump	☐ Gout	☐ Mononucleosis	☐ Stroke
☐ Bronchitis	☐ Heart Disease	☐ Multiple Sclerosis	☐ Thyroid Disease
☐ Bulimia	☐ Hepatitis	☐ Osteoporosis	☐ Tumors
☐ Cancer	☐ Hernia	☐ Pacemaker	☐ Ulcers

☐ Other Conditions:____

~ TURN OVER ~

When did your symptoms begin? ___________________________________

Is this condition getting progressively worse? ☐ YES ☐ NO ☐ UNCERTAIN

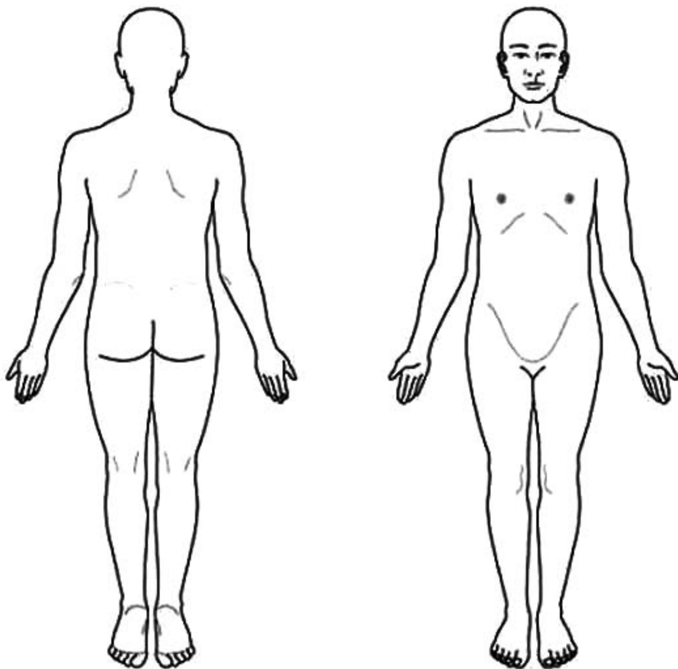
Are you pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Exercise? ☐ NONE ☐ MODERATE ☐ DAILY ☐ HEAVY

Work Activity? ☐ SITTING ☐ STANDING ☐ LIGHT LABOR ☐ HEAVY LABOR

Lifestyle: ☐ SMOKE_____ PACKS A DAY ☐ CANNIBIS USE ________ A DAY

☐ DRINK _____A WEEK_____A MONTH ☐ CAFFINE_____ A DAY ______ A WEEK



Mark an "X" for PAIN
Mark a "B" for BURNING
Mark a "N" for NUMBNES
Mark a "T' for TINGLING

Pain from 1 (least pain) to 10 (severe pain) __________

How often do you have this pain? _________________

Is the pain constant or does it come and go? ________

Does this interfere with:

☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending

OTHER INFORMATION YOU WOULD LIKE THE DOCTOR TO KNOW ABOUT:

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