

Patient Health History



Mankey Family
Chiropractic
Dr. Graham V. Mankey, D.C.
Dr. Allison Mankey, D.C.

Patient Name: _____ Date: _____

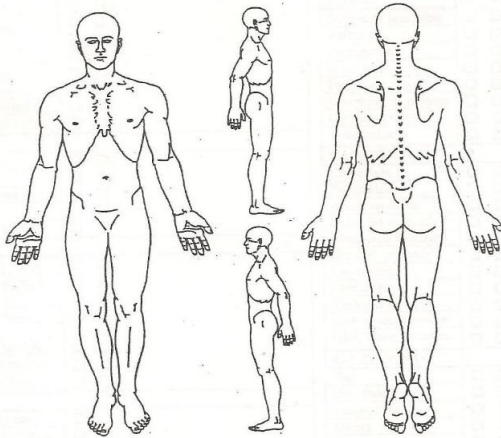
List each symptom/condition that brought you into our office:

#1: _____ #3: _____ Others: _____

#2: _____ #4: _____ Others: _____

If no complaint, mark: No Complaint/Wellness Care

Using the symbols below, mark on the pictures where you feel pain or discomfort:



- | | |
|----------------|-----|
| Numbness | === |
| Dull Ache | OOO |
| Burning | XXX |
| Sharp/Stabbing | /// |
| Pins, Needles | +++ |
| Other _____ | ^^^ |

History of EACH Complaint: (Please answer each of the following questions for EACH symptom/condition)

Symptom #1: _____

Pain or Problem Started on (date): _____

What do you think brought on/caused this condition/pain? _____

Pains are: Sharp Dull/ Ache Constant Intermittent Other _____

Does this pain shoot, radiate, or travel in your body? Yes No Where? _____

Are you experiencing numbness or tingling? Yes No Where? _____

Please **circle** where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Since this began, is it the: Same Better Worse

What activities aggravate this condition/pain? _____

What activities lessen this condition/pain? _____

What percentage of the day is this condition/pain present? 0% 25% 50% 75% 100%

How long does this condition/pain last? (# of secs/mins/hrs/days/etc.) _____

Is this condition worse during: Morning Afternoon Night All Day

Is this condition interfering with: Work Sleep Routine Other _____

Other Doctors seen for this condition: _____

Any home remedies? _____

Symptom #2: _____

Pain or Problem Started on (date): _____

What do you think brought on/caused this condition/pain? _____

Pains are: Sharp Dull/ Ache Constant Intermittent Other _____

Does this pain shoot, radiate, or travel in your body? Yes No Where? _____

Are you experiencing numbness or tingling? Yes No Where? _____

Please **circle** where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Patient Health History [Page 2]

Patient Name: _____ Date: _____

Since this began, is it the: Same Better Worse

What activities aggravate this condition/pain? _____

What activities lessen this condition/pain? _____

What percentage of the day is this condition/pain present? 0% 25% 50% 75% 100%

How long does this condition/pain last? (# of secs/mins/hrs/days/etc.) _____

Is this condition worse during: Morning Afternoon Night All Day

Is this condition interfering with: Work Sleep Routine Other _____

Other Doctors seen for this condition: _____

Any home remedies? _____

Symptom #3: _____

Pain or Problem Started on (date): _____

What do you think brought on/caused this condition/pain? _____

Pains are: Sharp Dull/ Ache Constant Intermittent Other _____

Does this pain shoot, radiate, or travel in your body? Yes No Where? _____

Are you experiencing numbness or tingling? Yes No Where? _____

Please **circle** where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Since this began, is it the: Same Better Worse

What activities aggravate this condition/pain? _____

What activities lessen this condition/pain? _____

What percentage of the day is this condition/pain present? 0% 25% 50% 75% 100%

How long does this condition/pain last? (# of secs/mins/hrs/days/etc.) _____

Is this condition worse during: Morning Afternoon Night All Day

Is this condition interfering with: Work Sleep Routine Other _____

Other Doctors seen for this condition: _____

Any home remedies? _____

Symptom #4: _____

Pain or Problem Started on (date): _____

What do you think brought on/caused this condition/pain? _____

Pains are: Sharp Dull/ Ache Constant Intermittent Other _____

Does this pain shoot, radiate, or travel in your body? Yes No Where? _____

Are you experiencing numbness or tingling? Yes No Where? _____

Please **circle** where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Since this began, is it the: Same Better Worse

What activities aggravate this condition/pain? _____

What activities lessen this condition/pain? _____

What percentage of the day is this condition/pain present? 0% 25% 50% 75% 100%

How long does this condition/pain last? (# of secs/mins/hrs/days/etc.) _____

Is this condition worse during: Morning Afternoon Night All Day

Is this condition interfering with: Work Sleep Routine Other _____

Other Doctors seen for this condition: _____

Any home remedies? _____

Patient Name: _____ Date: _____

Do you have any previous imaging?: X-ray MRI CT Other _____

Place of Service _____

I authorize Mankey Family Chiropractic to online access of all images, reports and any other information relating to my condition. Please Sign _____

Please mark any of the following conditions or symptoms that you have now or have experienced:

- Headaches
- Drop Attacks
- Loss of Balance
- Loss of Memory
- Double Vision
- Chest Pains
- High Blood Pressure
- Painful Urination
- Weight Loss
- Difficulty breathing at night
- Dizziness
- Loss of consciousness
- Pain in Hands or Arms
- Difficulty Swallowing
- Nystagmus
- Heart Attack
- Stroke
- Fever
- Pain waking you up at night
- Fainting
- Numbness
- Pain in Legs or Feet
- Difficulty Speaking
- Nausea
- Shortness of Breath
- Cancer
- Lights Bother Eyes
- Loss of Smell or Taste

NONE OF THE ABOVE APPLY

Current Health Habits:

- Did/do you smoke? Yes No How much & how often? _____
- Did/do you drink alcohol? Yes No How much & how often? _____
- Did/do you drink caffeine? Yes No How much & how often? _____
- Do you drink water? Yes No How much & how often? _____
- Do you eat 7-14 servings of fruits & veges/day? Yes No # of servings? _____
- Drugs, prescription, OTC, recreational? Yes No List: _____
- Exercise regularly? Yes No Type? _____
- Have you been in accidents/trauma? Yes No List: _____
- Any current/previous fractures? Yes No List: _____
- Hobbies/Sports injuries? Yes No List: _____
- Daily time spent driving? _____
- Physical stress? Yes No Explain? _____
- Emotional/Mental stress? Yes No Explain? _____
- Did/do you have occupational stress? Yes No Explain? _____
- Do you sleep well, hours of sleep? Yes No Hours? _____
- Sleeping posture: Side Stomach Back All of the above

Past History:

- Any major illnesses? Yes No List: _____
- Any previous surgeries? Yes No List & Date: _____
- Any previous hospitalizations? Yes No List: _____
- Any allergies? Yes No List: _____

Family History:

- Is there a family history of: No family history of the conditions listed below
- | | Arthritis | Heart/Blood Disease | Cancer | Diabetes | Other _____ | Unknown |
|---------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Father's side | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mother's side | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient Signature _____ Date _____