Dynamic Rehab LLC

Confidential Patient History

Patient's Name: _____ Date: _____

Please complete this form and questionnaire. If you need assistance, please ask. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

In general, would you say your heath is: ☐ Excellent ☐Very Good☐ Good ☐ Fair ☐Poor

Past Patient Health:

1. Have you ever experienced your present problem before consulting us:
   ☐Yes ☐No If yes, when: _____. Was treatment provided☐Yes ☐No
   If yes, by whom: _____. Outcome: _____.
2. Have you ever had a stroke or issues with blood clotting? ☐Yes ☐No
   If yes, please explain: _____.
3. Have you recently experienced dizziness, unexplained fatigue, weight loss, or blood loss?
   ☐Yes ☐No If yes, please explain: _____.
4. Are you HIV positive, or have a blood borne pathogen disease? ☐Yes ☐No
5. Have you ever had any major illnesses, injuries, cancer, hospitalizations, accidents, or surgeries?
   ☐Yes ☐No If yes, please explain: _____.

Date:	Injury/Fracture/Illness/Surgeries/Cancer	Treatment	Results

Systems Review Questions

Do you or have you ever had any problems with the following area(s)?

1. ____Eyes (Strain, Inflammation, Other)
2. ____Ears (Hearing Loss, Pain, Ringing, Other)
3. ____Nose (Bleeding, Discharge, Other)
4. ____Mouth, Throat
5. ____Heart, Chest Pain, Blood Pressure, Pacemaker
6. ____Lungs/Breathing/Shortness of Breath
7. ____Intestines/Bowels
8. ____Urinary
9. ____Muscles
10. ___Nerves (Numbness/Tingling, Other)
11. ___Joints/Bones
12. ___Skin
13. ___Internal Organs
14. ___Blood (Anemia, Other)
15. ___Allergies
16. ___Psychological/Emotional
17. ___Gynecological/Menstrual/Breast
18. ___Prostate/Testicular/Penile

If yes, or for any other conditions, please explain: _____
_____

Family History

List all the major diseases, such as cancer, diabetes, arthritis, heart, problems, multiple sclerosis, etc. and the relationship of the individual to you: _____
_____

Social History

Recreational activities/hobbies: _____

☐Yes ☐ No Do you exercise?
☐Yes ☐ No Do you smoke?
☐Yes ☐ No Do you consume alcohol?
☐Yes ☐ No Do you eat a balanced dairy free anti-inflammatory diet?
☐Yes ☐ No Do you get adequate sleep?
☐Yes ☐ No Is work stressful to you?
☐Yes ☐ No Is family life stressful to you?

Current Symptoms
Primary Complaint: _____

Secondary or related complaint(s) if any: _____

When did your symptoms begin: _____. Have you had this problem before? ☐Yes ☐No

Have you received chiropractic treatment previously? ☐Yes ☐No

If yes, explain: _____

Was the onset: ☐ Gradual ☐ Sudden Since the onset, has it gotten: ☐Worse ☐Better

Describe what caused the pain: _____

Have you detected possible relationship of your current complaint with any of the following:

☐ Muscle Weakness ☐Bowel/Bladder Problems ☐ Digestion ☐ Cardiac/Respiratory Other: _____

Have you tried any self-treatment or taken any medication (over the counter or prescription):

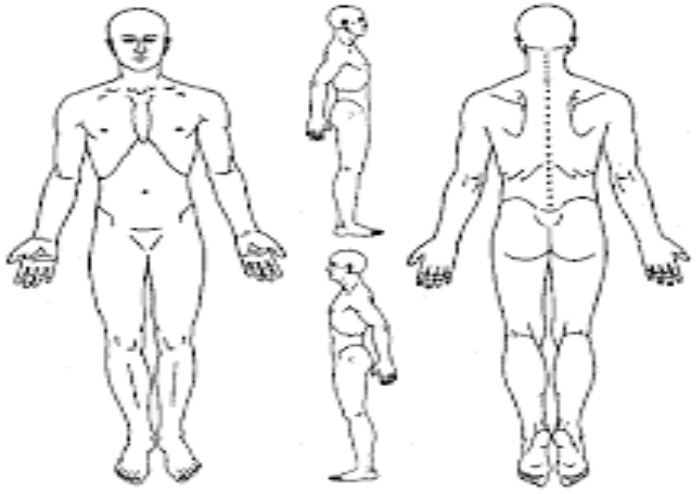
☐Yes ☐No If yes, please explain: _____ Outcome: _____

What medications are you currently taking: _____

Are you currently pregnant? ☐Yes ☐No

Are you currently taking anti-coagulant or blood thinning medication? ☐Yes ☐No

Do you have a current or recent infection? ☐ Yes ☐ No Explain: _____



Pain Chart	
Please mark the areas of pain by using these codes:	
B	Burning
D	Dull/Ache
N	Numbness/Tingling
T	Throbbing
S	Stabbing/Sharp

Severity of Pain
List region(s) of pain and circle the number which represents the intensity of your pain, with 0 being no pain, and 10 being unbearable pain:

1. Primary Complaint: _____ 1 2 3 4 5 6 7 8 9 10
2. Secondary Complaint: _____ 1 2 3 4 5 6 7 8 9 10
3. Tertiary Complaint: _____ 1 2 3 4 5 6 7 8 9 10