Date: ______________

Patient Demographics

Full Legal Name: ____ Nickname: _____________________
Date of Birth: _________________ SSN (optional): ____
Address: ____
Street City State Zip
Phone: ______________________ home / cell / work Cell Phone Carrier: _____________________________
(for text/email reminders)
Email Address: ____
Occupation: _________________________________ Employer: ___________________________________
Gender: Male ☐ / Female ☐ Marital Status: Single ☐ / Married ☐ Number of Children and Ages________________
Spouse's Name: ______________________________ DOB: ______________ Phone: __________________
Emergency Contact Name: _________________________ Emergency Contact Phone: _____________________
How did you hear about our office? ____

History of Complaint(s)

Please identify the condition(s) that brought you to the office and rate the pain on a 0 (no pain) to 10 (severe pain) scale.
Primary Complaint:______________________(/10) Second Complaint: ________________________ (/10)
Third Complaint:________________________(/10) Fourth Complaint:_________________________ (/10)
When did the primary complaint begin? ________________ Circle Pain: Sharp / Ache / Burn / Numb / Tingle / Dull
Nature of the Complaint: Constant / Intermittent (AM / PM) / Localized / Radiates: __________________________
How did the complaint/injury occur? Work / Automobile* / Other:_______________________________________
What aggravates the complaint?__________________ What lessens the complaint?_______________________
Is the condition getting better, worse, or staying the same? ____
Does the complaint interfere with any of the following activities of daily living? (Y / N) If so, circle all that apply:
work / sleep / sitting / standing / walking / dressing / physical activity / sports / school / house chores / other: _________
Have you consulted any other doctors/professionals for this complaint? ___________________________________
Any at home treatments? (Y / N) If so, circle all that apply: ice / heat / stretching / topical care (ie. Biofreeze or Bengay)

Past/Present Medical History

Medication List: ____
Vitamins/Supplements/Other:____
Pregnant: (Y / N) Weeks: ______ Postpartum: (Y / N) Breastfeeding: (Y / N) Birth Process: ________________
Prior Hospitalization (Y / N) If so, describe:____
Auto Collisions/Crashes (Y / N) If so, describe:____
Surgery: (Y / N)______________________________ Fracture/Broken Bones: (Y / N) ______________________
Sprain/Strain: (Y / N) _________________________ Concussion (Y / N) ______________________________

Social History

Consume Healthy Foods ☐ / Cardiovascular Exercise ☐ / Weightlifting ☐ / Hobbies: ☐
____
High Mental Stress ☐ / High Physical Stress ☐ / Difficulty Sleeping ☐
Smoking: Daily ☐ / Occasionally ☐ / Never ☐ Alcohol: Daily ☐ / Occasionally ☐ / Never ☐

Family History

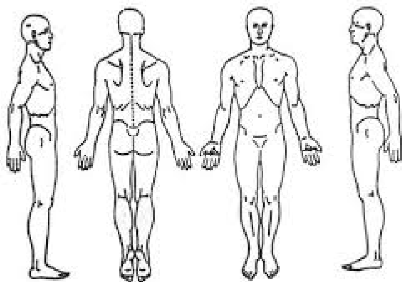
Does anyone in your family suffer from any of the following?
Heart Disease/Attack ☐ Relation:____________________ Cancer/Tumor ☐ Relation:________________________
Diabetes ☐ Relation:___________________ Osteo/Rheumatoid Arthritis ☐ Relation: ________________________
Other ☐ Relation: ____

DEYOUNG CHIROPRACTIC

Updated Health History Form

Full Legal Name: ____ Date: ___________________

Please circle on the diagram where you are experiencing pain or discomfort and mark all that apply from the list below:



☐ Neck Pain ☐ Mid Back Pain ☐ Low Back Pain
☐ Neck Stiffness ☐ Difficult Breathing ☐ Hip Joint Pain (L / R)
☐ Headaches Freq:________ ☐ Asthma ☐ Constipation
☐ Jaw Pain/TMJ ☐ Indigestion ☐ IBS/Digestive Issues
☐ Allergies/Sinus Issues ☐ Ulcers ☐ Menstrual Pain
☐ Thyroid Condition ☐ Diabetes ☐ Tingle/Numb Legs
☐ Tingle/Numb Arms ☐ Infertility ☐ Bladder Weakness
☐ Vertigo/Dizziness ☐ Chest Pain/Rib Pain ☐ Knee Pain (L / R)
☐ Visual Changes/Blurry ☐ High Blood Pressure ☐ Scoliosis Current Height:___________
☐ Hearing Loss/Ring ☐ Kidney Stones ☐ Poor Balance
Current Weight: __________lbs ☐ Trouble Sleeping ☐ Heart Attack/Issues ☐ Bed Wetting
☐ Shoulder Pain ☐ Tremors ☐ ADD/ADHD
☐ Depression ☐ Cancer:_________ ☐ Foot/Ankle Pain

QVAS (Quadruple Visual Analogue Scale)

What is your pain RIGHT NOW?	No Pain **0 1 2 3 4 5 6 7 8 9 10**	Worst Possible Pain
What is your TYPICAL or AVERAGE pain?	No Pain **0 1 2 3 4 5 6 7 8 9 10**	Worst Possible Pain
What is your pain level AT ITS BEST?	No Pain **0 1 2 3 4 5 6 7 8 9 10**	Worst Possible Pain
What is your pain level AT ITS WORST?	No Pain **0 1 2 3 4 5 6 7 8 9 10**	Worst Possible Pain

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Examination Section *****FOR DOCTOR USE ONLY***** **QVAS Score:_____**

Visit Notes: ____

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ORTHOPEDIC TESTING
(+ / -) Cervical Compression - Nerve Root Compression
(+ / -) Cervical Distraction - NRC/Cervical Sprain/Strain
(+ / -) Shoulder Depressor - Nerve Root Compression
(+ / -) Cervical Valsalva - Space Occupying Lesion/Disc
(+ / -) Spurling's Test - Cervical Radiculopathy
(+ / -) Brudzinski - Meningitis/Spinal Cord Lesion
(+ / -) Bechterew - Sciatic Nerve Compression
(+ / -) Patrick FABER - Hip Joint Pathology
(+ / -) Minor Sign - Radicular Disc Pain
(+ / -) Ely - Iliopsoas Spasm/Hip Joint/Lumbar Pathology
(+ / -) Nachlas - SI Joint/Lumbar Pathology
(+ / -) Straight Leg Raiser - Disc Pathology/Hamstring Spasm
(+ / -) Kemp's Test - Disc Involvement/Lumbar Radiculopathy
(+ / -) Lumbar Valsalva - Space Occupying Lesion/Disc
(+ / -) Braggard Sciatic Nerve Inflammation/Pain
RADIOLOGY/XRAYS
Cervical ☐ Cervical FLEX/EXT ☐ Thoracic ☐ Lumbar ☐

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RANGE OF MOTION
Cervical Region: (R / L)
Flexion ___/50 Extension ___/60 Rotation ___/80 Lat Flex ___/45
Lumbar Region: (R / L)
Flexion ___/60 Extension ___/25 Lateral Flexion ___/25
REFLEXES (R / L)
Biceps C5__ Brachial C6__ Triceps C7__ Patellar L4__ Achilles S1__
MOTOR TESTING
Deltoids C5___Biceps/Wrist Extensors C6___Triceps/Wrist Flexors C7__
Finger Adductors C8__ Finger Abductors T1__ Hip Flexor L1-L3__
Hip Abductor L4/L5 __ Foot Dorsiflex L4/L5 __ Foot Plantarflex S1 __
SENSORY TESTING (R / L) Hyperesthesia / Hypoesthesia
C5__ C6__ C7__ C8__ T1__ L3__ L4__ L5__ S1__
POSTURE ANALYSIS
Posture Screen Performed ☐ Posture Screen Sent to Email ☐

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