Welcome to Utah Chiropractic and Rehab!

As you know, health is the pinnacle of our lives. Without it we cannot participate in life as we wish to. We would like to thank you for choosing us to help improve your health and achieve a pain free existence.

Dr. Bruce MacDonald and Staff

Do you have Medicare? Yes No

Chiropractic Patient Information

Today's Date: _____

Full Name: _____ Preferred/Nickname: _____

Full Address: _____ DOB: _____

Sex (circle appropriate box)**:** Male Female **Occupation: _____**

Circle all that apply: Minor Single Married Widowed Separated Divorced Remarried

If you are a minor, a legal guardian must be present and give consent.

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Best time to contact me:_____ a.m. p.m. **On my:** Home Work Cell Text

Email: _____Would you like e-newsletter? Yes No

Have you received chiropractic care before? Yes No **Name of chiropractor: _____**

How did you hear about us?_____ Referred by? _____

Emergency contact & Relationship: _____ Phone: (___)_____

Do you have a PCP (primary care physician**)?** Yes No **May we contact them?** Yes No

Name of PCP: _____ Phone: (___)_____

Do you qualify for our student/Military/Local Business discount programs? Yes No

Patient Signature: _____ Today's Date _____

Signature of legal guardian if signing for minor: _____

Past Health History

Full Name: _____ Preferred/Nickname: _____

Have you ever had any serious illnesses from childhood to current? _____

_____

Have you ever been hospitalized or had any surgeries? _____

_____

Have you ever had any accidents, traumas, or injuries? _____

_____

Do you have any irregular menses? Yes No **Are you going through or currently in menopause?** Yes No

Are you currently pregnant? Yes No H**ow many total pregnancies? _____ Number of live births? _____**

When was your last gynecological exam? _____ Any abnormal findings? _____

_____

When was your last PAP smear? _____ Any abnormal findings? _____

_____

Do you have any known allergies? _____

Have you ever had any x-rays? _____

_____

When was your last physical: _____ What were the findings? _____

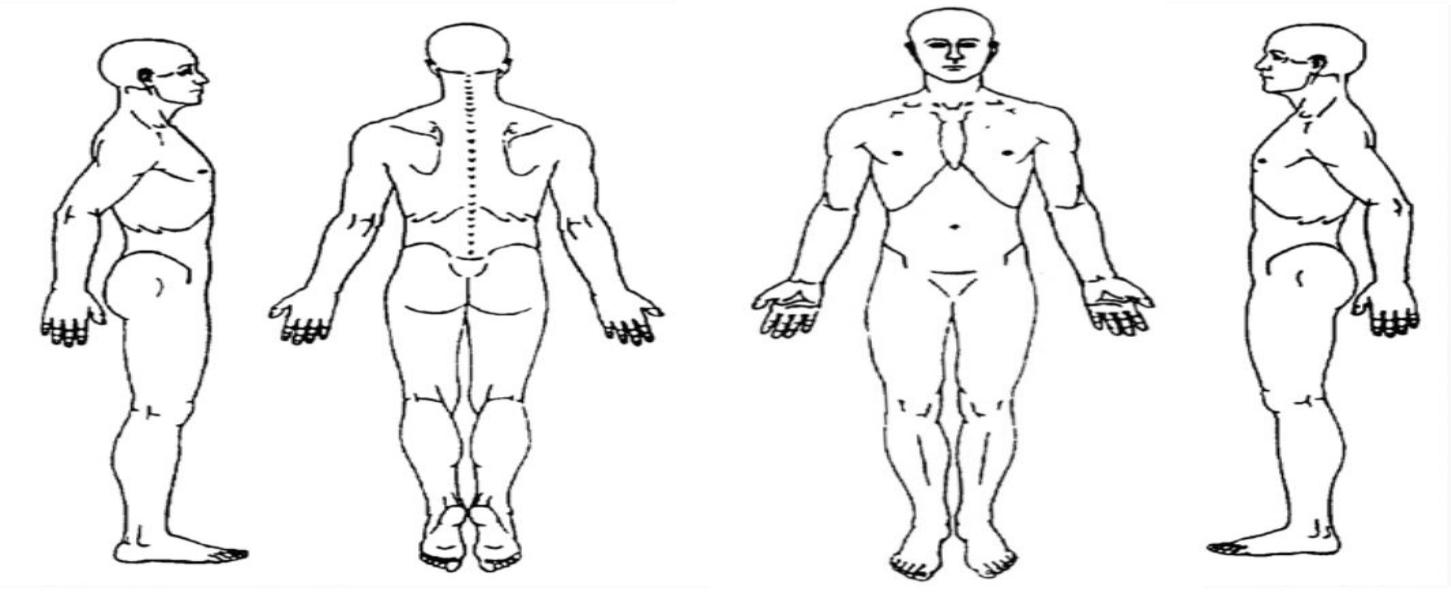
_____

When was your last dental check up? _____When was your last eye exam? _____

Please circle all the locations and write the following letters next to it that best describe what you are feeling:

DP= deep pain	**ST=** stabbing	**SP=** surface pain	**N=** numbness	**W=** weakness
D= dull	**T=** tingling	**A=** achy	**B=** burning	**L=** loss of feeling
SH= sharp	**V=** vague (can't pinpoint)		**R=** radiating pain (travels to different location)	

Please Describe Your Current Symptoms



Family Health History

Full Name: _____ Preferred/Nickname: _____

What are your ethnic backgrounds? _____

Have you or any one in your family (your parents, siblings, or grandparents**) ever been diagnosed or thought you might have any of the following conditions:** (circle all that apply)

Aids/HIV	Drug abuse	Osteoporosis
Alcoholism	Eczema	Polyps
Anemia	Fibromyalgia	Prostate problems
Ankylosing Spondylitis	Gall Bladder	Psoriasis
Anxiety	Glaucoma	Scoliosis
Arthritis	Gout	Seizures
Asthma	Headaches	Skin conditions
Back problems	Hearing loss	STD/STI
Birth defects	Heart conditions	Stroke
Blood clots	Hepatitis (any kind)	Suicidal thoughts
Bloody stools	High blood pressure	TB
Bruise easily	High cholesterol	Thyroid disorders
Cancer	Infertility	Vision loss
Chronic pain	Insomnia	Any other conditions_____
Constipation	Kidney disease	_____
Depression	Lupus	_____
Diabetes	Migraines	_____
Diarrhea	Multiple Sclerosis	_____
Diverticulitis	Obesity	

Name of Prescription	**Dosage**	**Started Taking it When?**

Name of Vitamins/Minerals	Dosage	Brand	Started Taking it When?

Any Other Supplements	Dosage	Brand	Started Taking it When?

Personal & Social History

What are some of you job duties? _____

How many hours do you work in a typical week? _____ Do you take breaks at work? Yes No

Hours of exercise in a day? _____ What are some of the activities you do? _____

_____

What are some interests or hobbies you participate in? _____

_____

How many hours of sleep do get on average? _____ Do you feel well rested when you awake? Yes No

How many bowel movements do you have in a day? _____ Have you noticed any changes in bowel movements lately (changes in frequency, color, consistency**)? _____**

Have you noticed any changes in urinary habits lately (changes in frequency, color, smell, urgency**)? _____**

_____

Do you currently, or have you ever, used alcohol products? Yes No **What kinds of alcohol were used? _____**

_____ How many drinks per week? _____

Do you currently, or have you ever, used tobacco products? Yes No **What kinds of tobacco were used? _____**

_____ How much per day? _____

Do you currently, or have you ever used illegal drugs? Yes No **Are you currently using? _____**

Are you currently, or have you ever been, in a relationship where you were physically hurt, threatened or made to feel afraid? **Yes No If YES, are you currently in that relationship?** Yes No

Are you seeking assistance/counseling? _____

Rate current stress level: (0-10, 0= No stress 10= worst stress imaginable**) _____ List some of the things stressing you out: _____**

Please list any other concerns or information you would like to discuss today:

_____

_____

_____

Review of Systems (Associated Symptoms)

General
Chills
Depression/nervousness
Dizziness/fainting
Excessive sweating
Fainting
Fever
Forgetfulness
Frequent colds/illnesses
Headache
Loss of sleep

Ears
Changes in hearing
Earaches
Ear discharge
Excessive earwax
Noises/ringing in ears

Eyes
Blurred vision
Crossed eyes
Double Vision
Dry, burning or itchy eyes
Excessive watery eyes
Flashes/halos in vision
Glasses/contacts
Mucus or discharge in eyes
Night blindness
Pain in eyes

Nose & Throat
Allergies/runny nose
Bleeding gums
Bloody noses
Cold sores
Cracks in corners of mouth
Difficulty swallowing
Dry mouth or nose
Grinding teeth
Hoarseness
Loss of smell or taste
Sinus problems
Sore throat

Skin & Hair
Bruise easily
Changes in moles
Cuts/wounds heal slowly
Dry/course hair
Dry, rough or scaly skin
Hair loss/thinning
Hives
Itching/rashes
Nails weak/ridged/split easily
Skin ulcers/sores

Gastrointestinal
Bad breath
Belching
Bloating/gas
Blood in stool
Constipation
Diarrhea
Excessive thirst
Heartburn
Hemorrhoids
Indigestion
Light/dark stools
Loss of appetite
Metallic or bitter taste in mouth
Nausea/vomiting
Poor appetite
Rectal pain/itching
Stomach pain
Vomiting blood

Urinary
Bed wetting
Bladder/kidney infection
Blood in urine
Difficulty urinating
Frequent urination at night
Incomplete urination/dribbling
Kidney stones
Pain when urinating

Cardiovascular
Cold hands/feet sensation
Chest pain
Dizzy or weak upon standing
High blood pressure
Low blood pressure
Hot sensations
Irregular/rapid heartbeat
Leg pain with walking
Poor circulation
Swelling feet/ ankles/legs
Tightness in chest
Varicose veins

Chest
Chest pain
Coughing
Difficulty breathing
Palpitations
Spitting up mucous
Spitting up blood
Wheezing

Female
Changes in menstrual cycle
Diminished/excessive sex drive
Hot flashes
Lumps in breast
Nipple discharge
Pain with intercourse
Painful or swollen breasts
Pelvic pain
Vaginal discharge
Vaginal pain/itching

Male
Diminished/excessive sex drive
Genital discharge
Genital rashes/sores
Pain in genitals
Pain in testicles
Prostate problems