



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 you improve your health and quality of life.

Dr. Bruce MacDonald and Staff

Do you have Medicare? Yes No

Massage 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 discount programs? Yes No

Would you like a FREE chiropractic consultation after your massage? 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 How many total pregnancies? _____ Number of live births? _____

Do you have any known allergies? _____

Have you ever had any x-rays? _____

PLEASE READ FIRST

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

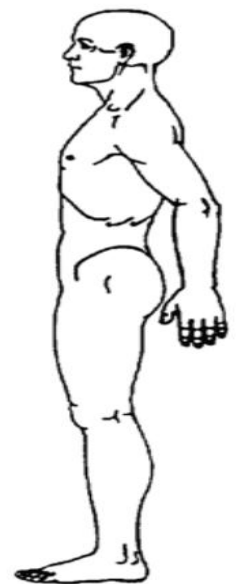
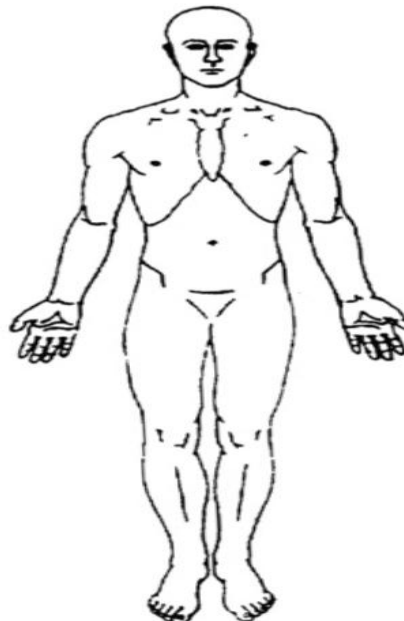
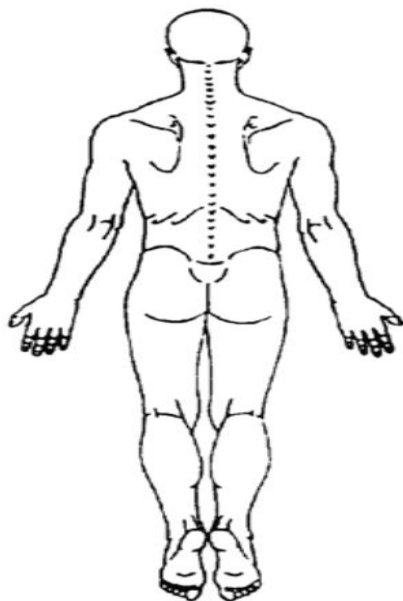
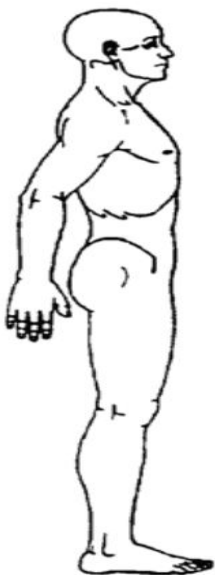
L= loss of feeling

SH= sharp

V= vague (can't pinpoint)

R= radiating pain (travels to different location)

Please Describe Your Current Symptoms



These symptoms may be associated with your chief complaint, or may be another problem altogether.

Please **circle all that apply** in each system of your body. If your symptoms are not described below, but you are experiencing them, please write it in the margin so Dr. MacDonald will be aware of them.

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