Patient History **AMON CHIROPRACTIC CENTER P.C.** - **Dr Richard P. Amon** - 3996 South 1900 West Roy, Utah 84067 Phone: 731-2200

Personal

Date: _____ **P**atient Name: _____ **Date of Birth:**_____

Address: _____ City: _____ UT: _____ Zip: _____

Phone: _____ Cell Phone: _____ email address: _____

Emergency Contact: _____ Phone: _____Relationship: _____
☐fSingle ☐Married ☐Divorced ☐Widow # kids____ Spouse:_____Referred by ☐ Phone Book☐ Ins Co ☐Website ☐ Friend

Insurance

Insurance Company: _____ Policy Number: _____ Policy began : _____

Insured: _____: Insureds Relationship: _____ Insureds Date Birth: _____ 2nd Insurance?: ☐Y ☐ N

Date Onset: mth day year_____ ☐ Acute ☐Chronic ☐ Maintenance ☐ Auto Accident ☐ On the Job Injury ☐ Similar off on years

Work Info

Occupation: _____

Sit: ☐ most of the day ☐ half the day ☐ little of the day
Computer work: ☐ most of the day ☐ half the day ☐ little of the day
Drive: ☐ most of the day ☐ half the day ☐ little of the day
Stand: ☐ most of the day ☐ half the day ☐ little of the day
On the phone: ☐ most of the day ☐ half the day ☐ little of the day
Manual Labor: ☐ most of the day ☐ half the day ☐ little of the day

Complaints

Describe Complaints: Areas hurting, The Cause, How It Started & Progressed:_____

_____

_____

Check Pain Areas Below (most severe 10)

☐ Neck: 0 1 2 3 4 5 6 7 8 9 10 ☐Constant: 75-100% of Time ☐Frequent 50-75% ☐Intermitten 25-50% ☐Occasional 0-25% of the time
☐ Upper Back 0 1 2 3 4 5 6 7 8 9 10 ☐Constant: 75-100% of Time ☐Frequent 50-75% ☐Intermitten 25-50% ☐Occasional 0-25% of the time
☐ Mid back 0 1 2 3 4 5 6 7 8 9 10 ☐Constant: 75-100% of Time ☐Frequent 50-75% ☐Intermitten 25-50% ☐Occasional 0-25% of the time
☐ Low back 0 1 2 3 4 5 6 7 8 9 10 ☐Constant: 75-100% of Time ☐Frequent 50-75% ☐Intermitten 25-50% ☐Occasional 0-25% of the time
☐ Headache ☐ Rt ____ ☐ Lt ___ 0 1 2 3 4 5 6 7 8 9 10 ☐Constant: 75-100% of Time ☐Frequent 50-75% ☐Intermitten 25-50% ☐Occasional 0-25% of the time
☐ Shoulder ☐ Arm ☐ Hand ☐ Hip ☐ Leg ☐ Foot 0 1 2 3 4 5 6 7 8 9 10 ☐Constant: 75-100% ☐Frequent 50-75% ☐Intermitten 25-50% ☐Occasional 0-25%

☐ Pain Localized or ☐ Pain Radiates: ☐ Rt Lt arm to __elbow, __wrist, __fingers __12345 ☐ Rt Lt leg to __knee, __ankle, __toes 12345
Pain is: ☐ Sharp ☐Dull ☐Diffuse ☐Achy ☐Burning ☐Shooting ☐Stiff ☐Numb ☐Tingly ☐Sharp with motion, ☐Shooting ☐Stabbing ☐Electric
Since onset are Your Symptoms: ☐ Getting Better ☐ Not Changing ☐ Getting Worse _____
☐ **P**ain on what Motion? _____ **P**ain on what Activity? _____
Pain interfered with work ☐Not at all ☐Slightly ☐Moderately ☐Substantially ☐Extremely +Affect Social Activity ☐Not ☐Slight ☐Substantial ☐Extreme
☐ Seen other Chiropractor for these problems ☐ ER ☐ Primary Care Physician ☐ Physical Therapist ☐ Neurologist ☐ Orthopedist ☐ Massage T
☐ Consider this problem to be ☐ mild ☐ moderate ☐ severe in nature
It is aggravated by:☐ Bending ☐ Driving ☐ Extending ☐ Sports ☐ Sleep ☐ Stairs ☐ Rising Up ☐ Standing ☐ Stress ☐ Walk ☐ Computer ☐ Work
☐ Pain at Rest ☐ Worse morning ☐ Night ☐ Laying back/side/stomach ☐ Lifting ☐ Twist ☐ _____
It is helped by: ☐ Adjustments ☐ Ibuprofen ☐ Tylenol ☐ Rx Meds ☐ Massage ☐ Rest ☐ Ice ☐ Heat ☐ Stand ☐ Sit ☐ Lay w/ Knees Bent ☐ Walk

Activities that have been **limited** due to your condition: _____ Work Days Lost _____
Rate your overall Health: ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor **Rate your level of exercise:** ☐ Strenuous ☐ Moderate ☐ Light ☐ None

Do you have any family members with ☐ Rheumatoid Arthritis ☐ Cancer ☐ Heart problems ☐ Lupus ☐ Diabetes ☐ ALS – Who:_____

History

Check if apply: ☐ extremity pain ☐ jaw pain ☐ joint pain/stiffness ☐ arthritis ☐ cancer ☐ tumor ☐ arthritis ☐ sinus ☐ high blood pressure ☐ heart attack ☐ chest pains ☐ stroke ☐ angina ☐ kidney stones/disorder ☐ bladder infections ☐ painful urination ☐ loss of bladder control ☐ prostate problems ☐ abnormal weight change ☐ loss of appetite ☐ abdominal pain ☐ ulcer hepatitis ☐ liver/gall bladder problems ☐ fatigue ☐ muscle incoordination ☐ visual problems ☐ dizziness ☐ diabetes ☐ excessive thirst ☐ frequent urination ☐ smoking/tobacco use ☐ drug/alcohol dependency ☐ allergeies ☐ depression ☐ epilepsy ☐ dermatitis ☐ HIV/Aids ☐ birth control use ☐ Pace Maker ☐ Pregnant

Medical History

List Surgeries you've had: _____

List Doctors seen for what conditions: _____

List Medications you take: _____

List Over the Counter Medications you take: _____

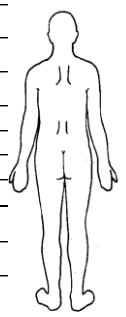
List Nutritional Supplements you take: _____

What activities do you enjoy outside of work? ☐ Basketball ☐ Golf ☐ Hiking ☐ Walking ☐ Weight Lift ☐ Yard Work ☐ _____

List any hospitalizations? _____

Visited a Chiropractor before? Results ☐ Good ☐ Fair ☐ Mixed ☐Poor _____

List any past traumas: Falls, Fractures, Auto Accidents: Date/ Describe details:_____



Other Information you think will help us help you: _____

_____

If Emergency Contact: _____ Phone: _____

Mark Your Pain Areas on the Figure: Ache XXX Burning *** Stabbing /// Numbness000

I certify that the above information is true and correct

Date: _____ Patient or Guardian: _____