Personal Health Profile

Name	Date	Date of Birth	Weight	Height	Age	Marital status

Occupation	Number of children and ages	Name of Spouse

Referred by	Date problem started

Other doctors seen for this problem

Diagnosis

Describe current problem

Have you had this problem before? ❑ No ❑ Yes If yes, describe below:

Does your present complaint involve any of the following:

- ❑ Dizziness
- ❑ Earaches
- ❑ Ringing in ears
- ❑ Fainting
- ❑ Headaches
- ❑ Poor appetite
- ❑ Shoulder/arm pain R/L
- ❑ Numbness/tingling in shoulder/arm R/L
- ❑ Pain between shoulders
- ❑ Hip pain R/L
- ❑ Thigh pain R/L
- ❑ Calf pain R/L
- ❑ Foot pain R/L
- ❑ Numbness or tingling in leg/foot R/L
- ❑ Sinus trouble
- ❑ Sore throat
- ❑ Visual disturbance
- ❑ Pain in abdomen
- ❑ Stomach nausea
- ❑ Vomiting
- ❑ Gas
- ❑ Indigestion
- ❑ Diarrhea
- ❑ Constipation
- ❑ Pain across belt line

What position, movement, or activity makes this worse?

What do you do, take, or put on this that helps?

Do you have regular troubles with:

- ❑ Your present complaint
- ❑ Headaches
- ❑ Neck pain
- ❑ Sinus trouble
- ❑ Sore throat
- ❑ Canker sores
- ❑ Deafness
- ❑ Dizziness
- ❑ Earaches
- ❑ Eyes
- ❑ Lower back pain
- ❑ Shoulder pain R/L
- ❑ Between shoulder pain
- ❑ Arm pain R/L
- ❑ Hand pain R/L
- ❑ Hip pain R/L
- ❑ Leg pain R/L
- ❑ Acid stomach
- ❑ Nervous stomach
- ❑ Bladder infections
- ❑ Menstrual cramping or irregularity
- ❑ Constipation
- ❑ Diarrhea
- ❑ Hemorrhoids
- ❑ High or low blood pressure

Have you ever had:

- ❑ Cancer
- ❑ Diabetes
- ❑ Heart trouble
- ❑ Stroke/TIA
- ❑ Kidney infections
- ❑ MS
- ❑ Ulcers
- ❑ Pneumonia

When did you last visit a:

Dentist ❑ Within 1 year ❑ When _____

Family doctor ❑ Within 1 year ❑ When _____

Eye doctor ❑ Within 1 year ❑ When _____

Chiropractor ❑ Within 1 year ❑ Who _____

Last X-rays taken (when/why): _____

List past surgeries or serious illnesses and date: _____

List past broken bones and date: _____

List past auto accidents or serious falls and date: _____

List medications you take now or in the past: _____

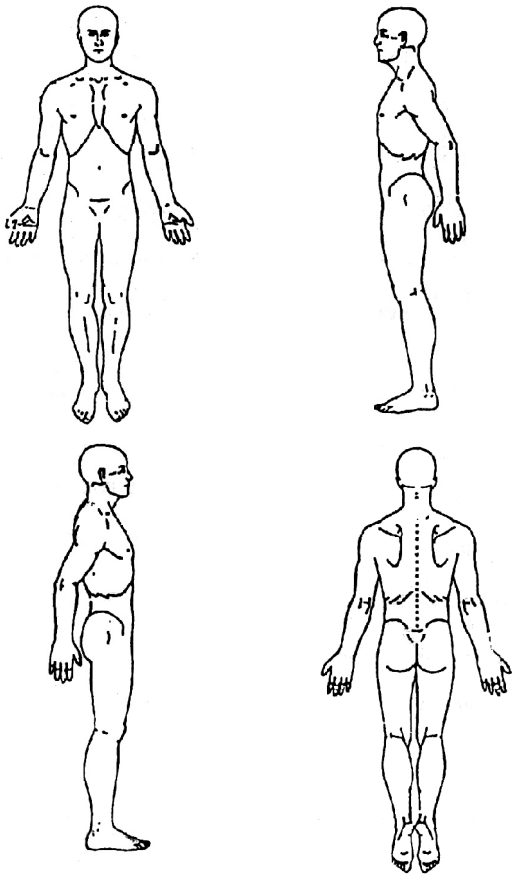
My activity is restricted: (mark on line below)

No Restrictions ——— Bed Ridden

Today my pain is: (mark on line below)

No Pain ——— Unbearable Pain

Please mark on the drawings the location of your complaint.



Are you currently pregnant: ❑ Yes ❑ No ❑ Not sure

Do you currently:

- ❑ Smoke _____, packs per day
- ❑ Use narcotics
- ❑ Consume alcohol, ❑ Frequently ❑ Infrequently
- ❑ I have the following conditions (not listed above): _____

❑ These are true answers of myself, _____
Signed

The Chiropractic Offices of Dr. Jason Prigge, Dr. Gib Garberg, and Dr. Brian Larsen. 507 Knight St., Richland, Washington 99352, 509-943-4919