

# MCDonald Chiropractic Acupuncture History

## Patient Information

Date: \_\_\_\_\_

\_\_\_\_\_  
Name

\_\_\_\_\_  
Best Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Marital Status

\_\_\_\_\_  
Date of Birth (Month/Day/Year)

\_\_\_\_\_  
Email

\_\_\_\_\_  
Occupation

\_\_\_\_\_  
Emergency Contact

\_\_\_\_\_  
Emergency Contact Phone Number

\_\_\_\_\_  
How did you hear about us

## Patient Health History

What are your main health concerns to be treated?

1) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_

Medications or Supplements currently taking:

\_\_\_\_\_  
Surgeries/Major illnesses or accidents:

Check symptoms you have or have had in the last 60 days:

### Muscles/Joints/Bones

Tremors  Cramps  Swollen Joints  Painful Joints  Loss of Movement  Muscle Twitches  Body Aches

### Pain, Weakness and/or Numbness

Hands  Arms  Wrists  Shoulders  Upper Back  Neck  Headache  Face/Jaw  Mid Back

Low Back  Hips  Legs  Knees  Ankles  Feet

### Eyes/Ears/Nose/Throat/Respiratory

Runny Nose  Stuffy Nose  Post Nasal Drip  Sinus Problems  Cough  Sore Throat

Difficulty breathing  Itchy Eyes  Blurred or worsening vision  Red Eyes  Ringing in Ears

Pressure in Ears  Loss of Hearing

### Skin

Itching/Rash  Bruise Easily  Excessive Sweating  Acne  Feel Hot  Feel Cold  Sore won't heal

### Cardiovascular

Chest Pain  Irregular beat  Rapid Heartbeat  High Blood Pressure  Fainting  Dizziness  Heart Disease