Patient Health History

Mankey Family Chiropractic
Dr. Graham V. Mankey, D.C.
Dr. Allison Mankey, D.C.

Patient Name:_____ Date:_____

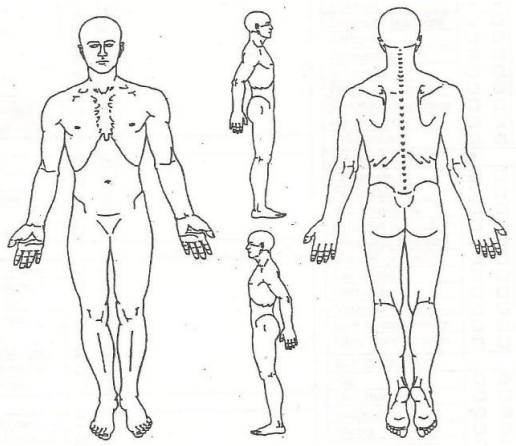
List each symptom/condition that brought you into our office:

#1:_____ #3:_____ Others:_____

#2:_____ #4:_____ Others:_____

If no complaint, mark: ❑ No Complaint/Wellness Care

Using the symbols below, mark on the pictures where you feel pain or discomfort:



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / / /
Pins, Needles	+ + +
Other _____	^ ^ ^

History of <u>EACH</u> Complaint: (Please answer each of the following questions for EACH symptom/condition)

Symptom #1:_____

Pain or Problem Started on (date):_____

What do you think brought on/caused this condition/pain?_____

Pains are: ❑ Sharp ❑ Dull/ Ache ❑ Constant ❑ Intermittent ❑ Other_____

Does this pain shoot, radiate, or travel in your body? ❑ Yes ❑ No Where?_____

Are you experiencing numbness or tingling? ❑ Yes ❑ No Where?_____

Please **circle** where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Since this began, is it the: ❑ Same ❑ Better ❑ Worse

What activities aggravate this condition/pain?_____

What activities lessen this condition/pain?_____

What percentage of the day is this condition/pain present? ❑ 0% ❑ 25% ❑ 50% ❑ 75% ❑ 100%

How long does this condition/pain last? (# of secs/mins/hrs/days/etc.)_____

Is this condition worse during: ❑ Morning ❑ Afternoon ❑ Night ❑ All Day

Is this condition interfering with: ❑ Work ❑ Sleep ❑ Routine ❑ Other_____

Other Doctors seen for this condition:_____

Any home remedies?_____

Symptom #2:_____

Pain or Problem Started on (date):_____

What do you think brought on/caused this condition/pain?_____

Pains are: ❑ Sharp ❑ Dull/ Ache ❑ Constant ❑ Intermittent ❑ Other_____

Does this pain shoot, radiate, or travel in your body? ❑ Yes ❑ No Where?_____

Are you experiencing numbness or tingling? ❑ Yes ❑ No Where?_____

Please **circle** where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Patient Name:_____ Date:_____

Since this began, is it the: ❑ Same ❑ Better ❑ Worse
What activities aggravate this condition/pain?_____
What activities lessen this condition/pain?_____
What percentage of the day is this condition/pain present? ❑ 0% ❑ 25% ❑ 50% ❑ 75% ❑ 100%
How long does this condition/pain last? (# of secs/mins/hrs/days/etc.)_____
Is this condition worse during: ❑ Morning ❑ Afternoon ❑ Night ❑ All Day
Is this condition interfering with: ❑ Work ❑ Sleep ❑ Routine ❑ Other_____
Other Doctors seen for this condition:_____
Any home remedies?_____

Symptom #3:_____
Pain or Problem Started on (date):_____
What do you think brought on/caused this condition/pain?_____
Pains are: ❑ Sharp ❑ Dull/ Ache ❑ Constant ❑ Intermittent ❑ Other_____
Does this pain shoot, radiate, or travel in your body? ❑ Yes ❑ No Where?_____
Are you experiencing numbness or tingling? ❑ Yes ❑ No Where?_____
Please **circle** where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Since this began, is it the: ❑ Same ❑ Better ❑ Worse
What activities aggravate this condition/pain?_____
What activities lessen this condition/pain?_____
What percentage of the day is this condition/pain present? ❑ 0% ❑ 25% ❑ 50% ❑ 75% ❑ 100%
How long does this condition/pain last? (# of secs/mins/hrs/days/etc.)_____
Is this condition worse during: ❑ Morning ❑ Afternoon ❑ Night ❑ All Day
Is this condition interfering with: ❑ Work ❑ Sleep ❑ Routine ❑ Other_____
Other Doctors seen for this condition:_____
Any home remedies?_____

Symptom #4:_____
Pain or Problem Started on (date):_____
What do you think brought on/caused this condition/pain?_____
Pains are: ❑ Sharp ❑ Dull/ Ache ❑ Constant ❑ Intermittent ❑ Other_____
Does this pain shoot, radiate, or travel in your body? ❑ Yes ❑ No Where?_____
Are you experiencing numbness or tingling? ❑ Yes ❑ No Where?_____
Please **circle** where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Since this began, is it the: ❑ Same ❑ Better ❑ Worse
What activities aggravate this condition/pain?_____
What activities lessen this condition/pain?_____
What percentage of the day is this condition/pain present? ❑ 0% ❑ 25% ❑ 50% ❑ 75% ❑ 100%
How long does this condition/pain last? (# of secs/mins/hrs/days/etc.)_____
Is this condition worse during: ❑ Morning ❑ Afternoon ❑ Night ❑ All Day
Is this condition interfering with: ❑ Work ❑ Sleep ❑ Routine ❑ Other_____
Other Doctors seen for this condition:_____
Any home remedies?_____

Patient Name:_____ Date:_____

Do you have any previous imaging?: ❑ X-ray ❑ MRI ❑ CT ❑ Other_____

Place of Service_____

I authorize Mankey Family Chiropractic to online access of all images, reports and any other information relating to my condition. Please Sign_____

Please mark any of the following conditions or symptoms that you have now or have experienced:

❒ Headaches	❒ Dizziness	❒ Fainting
❒ Drop Attacks	❒ Loss of consciousness	❒ Numbness
❒ Loss of Balance	❑ Pain in Hands or Arms	❒ Pain in Legs or Feet
❒ Loss of Memory	❒ Difficulty Swallowing	❒ Difficulty Speaking
❑ Double Vision	❒ Nystagmus	❒ Nausea
❒ Chest Pains	❒ Heart Attack	❒ Shortness of Breath
❒ High Blood Pressure	❒ Stroke	❒ Cancer
❒ Painful Urination	❒ Fever	❒ Lights Bother Eyes
❒ Weight Loss	❒ Pain waking you up at night	❒ Loss of Smell or Taste
❒ Difficulty breathing at night		

❒ **NONE OF THE ABOVE APPLY**

Current Health Habits:

Did/do you smoke?	❑ Yes ❑ No	How much & how often?_____
Did/do you drink alcohol?	❑ Yes ❑ No	How much & how often?_____
Did/do you drink caffeine?	❑ Yes ❑ No	How much & how often?_____
Do you drink water?	❑ Yes ❑ No	How much & how often?_____
Do you eat 7-14 servings of fruits & veges/day?	❑ Yes ❑ No	# of servings?_____
Drugs, prescription, OTC, recreational?	❑ Yes ❑ No	List:_____
Exercise regularly?	❑ Yes ❑ No	Type?_____
Have you been in accidents/trauma?	❑ Yes ❑ No	List:_____
Any current/previous fractures?	❑ Yes ❑ No	List:_____
Hobbies/Sports injuries?	❑ Yes ❑ No	List:_____
Daily time spent driving?	_____	
Physical stress?	❑ Yes ❑ No	Explain?_____
Emotional/Mental stress?	❑ Yes ❑ No	Explain?_____
Did/do you have occupational stress?	❑ Yes ❑ No	Explain?_____
Do you sleep well, hours of sleep?	❑ Yes ❑ No	Hours?_____
Sleeping posture:	❑ Side ❑ Stomach ❑ Back ❑ All of the above	

Past History:

Any major Illnesses?	❑ Yes ❑ No	List:_____
Any previous surgeries?	❑ Yes ❑ No	List & Date:_____
Any previous hospitalizations?	❑ Yes ❑ No	List:_____
Any allergies?	❑ Yes ❑ No	List:_____

Family History:

Is there a family history of: ❒ No family history of the conditions listed below

	Arthritis	Heart/Blood Disease	Cancer	Diabetes	Other_____	Unknown
Father's side	❒	❒	❒	❒	❒	❒
Mother's side	❒	❒	❒	❒	❒	❒

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient Signature_____ Date_____