

7th Street Chiropractic & Acupuncture Center P.C
Dr. Evan Antolik
3135-7th Street, Moline, IL 61265
(309)762-1431

Patient History

Name _____ Date _____

Address _____ City _____

State _____ City _____ Zip Code _____

Phone _____ Birth Date _____ Sex (circle) male female

Social Security No. _____ Driver License No. _____

Employer _____ Type of Work _____

Work Phone _____ Spouse's Name _____

Spouse's S.S No. _____ Spouse's Employer _____

Name & age of children _____

Name & Number of Emergency Contact _____

Relationship to you _____

E-mail Address _____

Current Health

Current Health Problems _____

Other Doctor seen for this problem? (circle) yes no If yes then who?

Type of Treatment _____ Results _____

When did this begin? _____ Has it occurred before? yes no

Is the condition (circle one) job related auto accident home injury fall other

Date & time of accident _____ Reported to employer? yes no

Please list any drugs or medications you are currently taking _____

Past Health History

Please list any major surgery or operations you have had _____

Major Falls, Accidents or hospitalizations _____

Have you seen a chiropractor before? yes no Doctor Seen _____

Date of last visit _____

On the following page are lists of diseases which may seem unrelated to the purpose of your visit however, these questions must be answered carefully as these problems can affect the overall course of your care:

Check off all of the following that you have ever had:

Pneumonia

Rheumatic Fever

Polio

Tuberculosis

Whooping Cough

Anemia

Measles

Mumps

Small Pox

Chicken Pox

Diabetes

Cancer

Heart Disease

Thyroid

Influenza

Pleurisy

Arthritis

Epilepsy

Mental Disorders

Lumbago

Eczema

Have you ever tested positive for HIV? (circle) yes no

Please check all that apply to you in the last six months:

Muscular-skeletal

low back pain

pain between
shoulders

neck pain

arm pain

joint pain/stiffness

walking problems

difficulty chewing

general stiffness

Nervous System

nervous

numbness

paralysis

dizziness

forgetfulness

confusion

depression

fainting

convulsions

__cold extremities

__stress

General

__fatigue

__allergies

__loss of sleep

__fever

__headaches

Gastro-intestinal

__poor/excessive
appetite

__excessive thirst

__frequent nausea

__vomiting

__diarrhea

__constipation

__hemorrhoids

__liver problems

__gall bladder trouble

__weight problems

__abdominal cramps

__gas/bloating

__heartburn

__black/bloody stool

__colitis

Genito-urinary

__bladder trouble

__painful/excessive
urination

__discolored urine

Cardio-pulmonary

__chest pain

__shortness of breath

__blood pressure
problems

__irregular heart beat

__heart problems

__lung problems

__varicose veins

__ankle swelling

__stroke

Eent

__vision problems

__dental problems

__sore throat

__ear aches

__hearing difficulty

__stuffed nose/sinus
problems

Male/Female

__menstrual irregular

__menstrual cramps

_____ Date of last
period?

_____ Are you
pregnant?

__vaginal pain/infection

__breast pain/lumps

__prostrate problems

__impotent

__ _____

Please list family members who have the same or similar problems as you do _____

Guardian or spouse's

signature authorizing care _____ Date _____

For Office Use Only – Do Not Write Below This Line

Diagnosis:

Analysis:

Patient Accepted: yes no _____

Doctor's Signature