

# **Thompson Family Chiropractic Clinic**

**Dr. Beth Thompson**

**Dr. Dean Thompson**

**Dr. Sue Copper**

400 16<sup>th</sup> Street Rock Island, Illinois 61201

(309) 793-1051

## **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
- difficultly 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
- prostate problems
- impotent
- \_\_\_\_\_

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

\_\_\_\_\_

