

PATIENT INFORMATION

Patient Name: Dr./Mr./Mrs./Ms. _____
Last Legal First Middle Initial
Name you prefer to be called (nickname): _____ Social Security #: _____
Phone #:() _____ Fax #:() _____ Cell #:() _____
E-mail: _____
Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Birth Date: _____ Sex: _____ Patient's Employer: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Phone #: () _____ Ext: _____ Occupation: _____
Please circle: single/married/domestic partners/divorced/other: _____ Spouse/partner's name: _____

PERSONAL HEALTH HISTORY

Have you seen Dr. Ezgur for anything before? No/Yes, explain: _____
Have you ever been to chiropractor before? No/Yes, what for? _____
Who referred you to our practice? Person: _____ Advertisement: _____
Are you, or might you be pregnant? No/Yes Do you have a pacemaker? No/Yes
What do you hope to do better or enjoy more when you regain your health? _____

When was your last physical exam? _____ Results: _____

Date, and results, if known, of any recent tests: cholesterol: _____ other: _____
Please list all current medications, vitamin/mineral supplements, herbs, including dosage (attach separate page if necessary): _____

If you smoke or have ever smoked, describe how much, and for how long: _____
Describe your recreational drug use: _____
Typical alcohol intake (#of drinks per day/per week): _____
Please list and describe all significant previous injuries (sprains, fractures, accidents, etc.): _____

Please list and describe all significant previous surgeries: _____

Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session: _____

Height: _____ Present Weight: _____ Weight one year ago: _____ Preferred Weight: _____
Any recent weight changes?: _____

SYMPTOM LIST

Please indicate which of the symptoms listed below that you have ever experienced, with the following coding system:

- "C" if you are currently experiencing this symptom
- "R" if you tend to experience this symptom on a regular or recurring basis
- "NW" if you've never fully recovered from (never been completely well since having this symptom)
- "P" if you've experienced this symptom in the past

GENERAL

- _____ Frequent or recurring Chills
- _____ Epilepsy/Convulsions/Seizure
- _____ Frequent or recurring Dizziness
- _____ Frequent or recurring Fainting
- _____ Frequent or recurring Fatigue
- _____ Frequent or recurring Fever
- _____ Headache
- _____ Frequent or recurring Sleep loss
- _____ Recent Weight Change
- _____ Anxiety/Panic Attacks
- _____ Depression
- _____ Frequent or recurring Sweats
- _____ Frequent/recurring hives/rashes
- _____ Frequent/recurring colds/flu
- _____ Vertigo
- _____ Fainting
- _____ Fears/Phobias

GENITO-URINARY/ENDOCRINE

- _____ Bedwetting
- _____ Frequent urination
- _____ Urinary tract infections
- _____ Painful urination
- _____ Painful menstruation
- _____ Prostate trouble
- _____ Loss of bowel/bladder control
- _____ Gall Stones
- _____ Blood in urine
- _____ Thyroid problems/Goiter
- _____ Kidney stones
- _____ Irregular menstrual cycle
- _____ Hot flashes
- _____ Diabetes
- _____ Pelvic Inflamm. Dis.
- _____ Infertility/Miscarriage

RESPIRATORY

- _____ Spitting up phlegm
- _____ Chest pain
- _____ Spitting up blood
- _____ Difficult breathing
- _____ Asthma
- _____ Wheezing
- _____ Chronic cough
- _____ Allergies

GASTROINTESTINAL

- _____ Bloating, belching, gas
- _____ Esophageal reflux
- _____ Constipation
- _____ Frequent heartburn
- _____ Ulcer
- _____ Digestive Problems
- _____ Parasites
- _____ Pain over stomach
- _____ Diarrhea
- _____ Vomiting
- _____ Nausea
- _____ Poor appetite
- _____ Candida/Yeast
- _____ Hernia

CARDIOVASCULAR

- _____ Hardening of arteries
- _____ High blood pressure
- _____ Pain over heart
- _____ Bad circulation/ankle swell
- _____ Rapid heart beat
- _____ Heart Disease
- _____ Palpitation/Ireg heart beat
- _____ Cold Hands &/or Feet

EYES, EARS, NOSE, THROAT

- _____ Frequent/recurring sore throat
- _____ Deafness
- _____ Dental problems
- _____ Ear problems/Infections
- _____ Sinus problems
- _____ Frequent/recurring nose bleeds
- _____ Vision problems
- _____ Canker sores
- _____ Cold sores

MUSCULOSKELETAL – pain, numbness, weakness in:

- _____ Low Back
- _____ Neck
- _____ Upper Back
- _____ Mid Back
- _____ Between Shoulder Blades
- _____ Shoulder Blade: R/L both
- _____ Shoulder: R/L both
- _____ Foot: R/L bunions/corns
- _____ Fibromyalgia
- _____ Arm: R/L both
- _____ Elbow: R/L both
- _____ Hand: R/L both
- _____ Leg: R/L both
- _____ Hip: R/L both
- _____ Knee: R/L both
- _____ Ankle: R/L both
- _____ Spinal curvature
- _____ Arthritis/Gout

OTHER

- _____ Abscesses
- _____ Acne
- _____ Alcohol/Drug Addiction
- _____ Anemia
- _____ Athlete's Foot/Fungal infection
- _____ Cancer
- _____ Chicken Pox
- _____ Eczema
- _____ Genital Warts
- _____ Warts
- _____ Hepatitis
- _____ Scarlet Fever
- _____ HIV
- _____ Chicken Pox
- _____ Dry/Cracked heels

OTHER

- _____ Mononucleosis
- _____ Psoriasis
- _____ Sexually Transmitted Disease
- _____ Whooping Cough
- _____ Ingrown Toenails/Hang-nails

OTHER

- _____ Genital Herpes
- _____ Pneumonia
- _____ Sexual Abuse
- _____ Worms
- _____ Teeth Problems/Cavities

OTHER

- _____ Mumps
- _____ Root Canal/gum disease
- _____ Stroke
- _____ Shingles
- _____ Penile/Vaginal Discharge

Finally, from the symptoms listed above, rank your most important 5-10 symptoms below, in terms of their priority, with 1 being the most important.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list any other symptoms that were not listed above: _____

Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:

- Symptom: _____ Family members also affected: _____
- Symptom: _____ Family members also affected: _____
- Symptom: _____ Family members also affected: _____
- Symptom: _____ Family members also affected: _____

Please list any other significant health problems of parents, grandparents, or siblings: _____

SPOUSE/PARTNER/FAMILY MEMBERS' OBSERVATIONS

If possible, it would be helpful to get any additional insight from your spouse, or other family members. Of importance are things difficult for one to observe of him or herself. This includes sleep behavior (snoring, talking, crying out during dreams, movements/positions, uncovering). Also useful are childhood behaviors, fears, traumas (physical or emotional), which might be remembered by a parent or older sibling.

Sleep behavior: _____

Childhood fears, behavior, trauma: _____

Any other observations: _____

NUTRITION

Which do you eat on a typical day: { } Breakfast { } Lunch { } Dinner # of snacks/day: _____

Please indicate the estimated number of servings of each of the following, which you eat on a typical day:

_____ Eggs	_____ Red Meat	_____ Fruits	_____ Yogurt	_____ Tofu/Soy	_____ Fish
_____ Cheese	_____ Spicy Foods	_____ Vegetables	_____ Grains, Rice, Pasta, Cereal, Bread	_____ Milk	_____ Bacon/Hot Dogs
_____ Desserts	_____ Chicken/Turkey	_____ Margarine	_____ Nuts/Seeds/Peanut Butter	_____ Sausage/Lunch Meats	
_____ Regular Soft Drinks	_____ Water	_____ Regular Coffee	_____ Decaf. Coffee	_____ Diet Soft Drinks	
_____ Fruit Juices	_____ Regular Tea	_____ Decaf. Tea	_____ Herbal Tea	_____ Sports Drinks (i.e., Gatorade)	

On a scale of 1-10, (10 being perfectly healthy) how healthy would you rate your diet: _____

If you try to follow a special diet (i.e., low fat, low cholesterol, low calorie, low sodium, low carb, diabetic), please describe: _____
