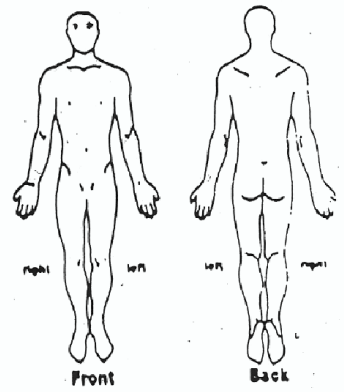


**PORTER CHIROPRACTIC, PLLC**

Dr. Dwain P. Porter, DC, MS

Doctor of Chiropractic

Masters of Science (Nutrition)



**HEALTH HISTORY**

Name \_\_\_\_\_ Age \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Date of last Chiropractic visit: \_\_\_\_\_

Occupational activities (bend, lift, stand, sit etc.) \_\_\_\_\_

Current problem is located where? \_\_\_\_\_

Please X area's of pain or problem on the above drawing.

When did current illness begin? \_\_\_\_\_ Have you had this problem in the past? \_\_\_\_\_

How would you describe the type of pain? Please circle! **Sharp, Dull, achy, burning shooting, stiff, numb, tingling.**

Scale of 1 to 10 (10 being the worst pain) describe: \_\_\_\_\_

How often do you experience the symptom? Circle one!

Constantly, Frequently, Occasionally, Intermittently.

What makes this pain worse? \_\_\_\_\_

What alleviates the pain? \_\_\_\_\_

What medical attention have you received for this current illness? \_\_\_\_\_

Have you received an MRI, CT scan, EMG, NCV, or Xray? \_\_\_\_\_

Have you been given a diagnosis? If so, What? \_\_\_\_\_

List current medications for this illness: \_\_\_\_\_

List all previous fractures: \_\_\_\_\_

List all previous surgeries: \_\_\_\_\_

List all medications: \_\_\_\_\_

List all previous diagnosed diseases: \_\_\_\_\_

Type of exercise and frequency: \_\_\_\_\_

Would you like to discuss nutritional healing, diet or weight loss programs? \_\_\_\_\_