OAK STREET CHIROPRACTIC CARE, LTD.
2 East Oak Street, Suite 1605
Chicago, IL 60611
oakstreetchiropractic.com
(312) 944-6269

New Patient Health History and Medical Questionaire

The purpose of chiropractic treatment is to improve your overall well being. To ensure the safest therapeutic approach, please provide a "yes" or "no" answer, to all of the following questions, by circling the appropriate response in regards to your health.

Please circle "yes" for all of the symptoms or conditions (past or present) in the list that apply to you, even if they do not seem related to your current problem. Please circle "no" if you do not have the listed symptoms or conditions (past or present).

Yes or No Joint Hypermobility
Yes or No Unstable joint(s)
Yes or No Severe bone demineralization
Yes or No Spinal bone tumors-benign
Yes or No Spinal bone tumors-malignant
Yes or No Bleeding disorders
Yes or No Anticoagulant therapy
Yes or No Shooting pain into arms or legs with weakness, numbness or tingling

Yes or No Acute rheumatoid arthritis
Yes or No Acute ankylosing spondylitis
Yes or No Acute fractures
Yes or No Acute Dislocations
Yes or No Healed fractures that may be unstable
Yes or No Healed dislocations that may be unstable
Yes or No Unstable Os Odontoideum
Yes or No Malignancies that involve the vertebral column
Yes or No Infection of bones or joints of the vertebral column
Yes or No Signs or symptoms of myelopathy or Cauda Equina Syndrome
Yes or No Vertebrobasilar insufficiency syndrome C/S
Yes or No Significant major artery aneurysm near the area of concern

Yes or No Acute/sub-acute injuries
Yes or No Thrombophlebitis
Yes or No Acute tissue sepsis
Yes or No Infections
Yes or No Tumors/cysts
Yes or No Pregnant
Yes or No Cardiac disease

Yes or No Developmental myositis ossificans (documented by x-ray)
Yes or No Recent exercise of an injured area
Yes or No Healing Fracture

Yes or No Local area of impaired peripheral circulation
Yes or No Pacemaker
Yes or No Extensive scar tissue (poor blood supply)
Yes or No Deep x-ray or other ionizing radiation in the last 6 months
Yes or No Cancer or malignancy
Yes or No Reduced consciousness or understanding
Yes or No Acute fever
Yes or No Raynaud's Disease
Yes or No Cryoglobulinemia
Yes or No Cold urticaria

Yes or No Thrombophlebitis
Yes or No Malignancy
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Yes or No Allergies to certain drugs
Yes or No Eczema
Yes or No Dermatitis
Yes or No Surgical skin lesions

Yes or No Open wound
Yes or No Infected wound
Yes or No Compromised circulation
Yes or No Carotid sinus (front of neck)
Yes or No Pregnancy
Yes or No History of epilepsy

Yes or No Lack of local thermal (heat) sensation
Yes or No Devitalized tissue e.g. after deep x-ray therapy
Yes or No Acute phase of inflammatory condition (bursitis, tenosynovitis, tendonitis)

Yes or No Skin eruptions (bruises, cuts, fractures, etc.)
Yes or No Sight of pain directly over a bone
Yes or No Varicose vein
Yes or No Unexplained calf pain

Yes or No Medications (list if "yes"):

1)
2)
3)
4)
5)

Yes or No Supplements or Vitamins (list if "yes"):

1)
2)
3)
4)
5)

Yes or No Diseases (list if "yes"):

1)
2)
3)
4)
5)

Yes or No Surgeries (list if "yes" with dates performed):

1)
2)
3)
4)
5)

Yes or No Diagnostic Tests (list if "yes" with facility and date performed):

1) Yes or No X-rays
2) Yes or No MRI
3) Yes or No CT
4) Yes or No Blood Tests
5) Yes or No Urinalysis

I have read the above and have indicated all of the conditions/situations regarding my health.

_____ _____

Patient's Signature **Date**