

**Total Touch Chiropractic Wellness Center**

3000 Beatties Ford Road  
Charlotte, NC 28216

Phone: 704-697-9818  
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**MEDICAL HISTORY APPLICATION**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Driver's License # \_\_\_\_\_

Email \_\_\_\_\_

Marital Status: (Married) (Single) (Widowed) (Divorced)

Name of Your Employer \_\_\_\_\_ Employer ID# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is your condition related to your employment? (YES) (NO)

Is your condition related to an auto accident? (YES) (NO)

If yes, please explain. \_\_\_\_\_

Name of Spouse's Employer \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Who will be responsible for bill? (Self) (Spouse) (Employer) (Insurance)

Insurance Type: (Health) (Workman's Comp) (Auto Policy) PIP or Claim # \_\_\_\_\_

How will payment be made? (Cash) (Check)

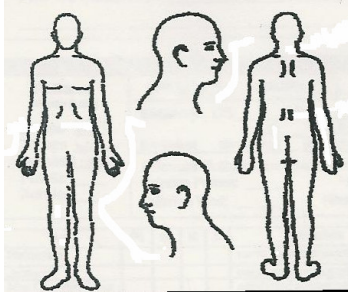
Some health conditions are the result of hereditary spinal weakness. Please provide the following information about your immediate family, including brothers, sisters, parents, and grandparents. This will give us a better understanding of your total health picture.

Relationship	Present and Past Health Problems

**Your Complaints**

- When did you first become aware of this problem? \_\_\_\_\_
- Rate your pain; 0 = no pain at all, 10 = worst pain possible. \_\_\_\_\_
- Do you feel? (circle) Sharp, dull sting, burning, throbbing, stabbing, electrical tingling, numb, others \_\_\_\_\_
- Is the pain or symptom (circle) constant, intermittent, or occasional?
- Is there (circle) tenderness, achiness, soreness, stiffness, tightness, weakness, tiredness?
- This problem is: (circle) Staying the same, getting worse, not sure.
- What makes your condition better? \_\_\_\_\_
- What makes your condition worse? \_\_\_\_\_
- Do the symptoms get worse with movement? (YES) (NO)
- Does this problem: (circle) cease with activity, interferes with activity, sometimes prevents activities, prevents all activities, interferes with biological processes.
- Have you ever had this problem or similar before? (YES) (NO) If yes, please explain: \_\_\_\_\_
- Have you ever received any treatment for this condition? (YES) (NO) If yes, where, when, and what were your results? \_\_\_\_\_
- Have you seen another doctor for this problem? (YES) (NO) If yes, when? \_\_\_\_\_

Please mark your problem area(s) of pain on the figures shown below, B=Burning, A=Aching, P=Pins and Needles, S=Stabbing and Sh=Shooting



Date Started \_\_\_\_\_ What caused it and how did it start? \_\_\_\_\_

Circle the symptoms you have noticed:

- |                        |                        |                     |                 |
|------------------------|------------------------|---------------------|-----------------|
| Headaches              | Irritability           | Numbness in Toes    | Buzzing in Ears |
| Neck Pain              | Chest Pain             | Shortness of Breath | Loss of Balance |
| Stiff Neck             | Dizziness              | Fatigue             | Fainting Spells |
| Sleeping Problems      | Head Seems too Heavy   | Depression          | Loss of Smell   |
| Back Pain              | Pins & Needles in Arms | Loss of Memory      | Loss of Taste   |
| Nervousness            | Ringling in Ears       | Diarrhea            | Tension         |
| Pins & Needles in Legs | Flushed Face           | Cold Feet           | Sensitive Eyes  |
| Numbness in Fingers    | Upset Stomach          | Constipation        | Cold Hands      |
| Fever                  | Cold Sweats            | Frequent Urination  | Hot Flashes     |

Symptoms other than listed above: \_\_\_\_\_

How has this condition interfered with your home, occupational, recreational, rest and/or sleep life? \_\_\_\_\_

Have you ever been in an automobile accident?

(No) (Past year) (Past 5 years) (Over 5 years)  
 Any accidents, falls, etc. that might have caused your problem? (NO) (YES)

If yes, please explain \_\_\_\_\_

Any medical diagnosis of your complaint? \_\_\_\_\_

What surgery has been done? \_\_\_\_\_

Drugs you're now taking: ( ) Nerve Pills ( ) Pain Killers ( ) Muscle Relaxers  
 ( ) "Pep" Pills ( ) Tranquilizers ( ) Insulin ( ) Birth Control ( ) Other \_\_\_\_\_

Females, are you pregnant? ( ) Yes ( ) No Date of last menstrual period \_\_\_\_\_

Chiropractor(s) consulted in the past year? (Name) \_\_\_\_\_

**FEES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED, TO INCLUDE EXAMINATIONS, TREATMENTS, AND ALL OTHERS UNLESS OTHER ARRANGEMEMNTS ARE MADE IN ADVANCE.**

Signature \_\_\_\_\_

Date \_\_\_\_\_