DR. BRIAN C. VETTER
PATIENT HISTORY
PLEASE PRINT CLEARLY

TODAY'S DATE:____/____/____

NAME: Last ______________________________ First________________________________ M.I. ________

ADDRESS ______________________________ City __________________ State _____ Zip _____________

MARITAL STATUS: M S D W DATE OF BIRTH: ____/____/____ SS# _______-______-________

HOME PHONE: (____) ____-_____ WORK PHONE: (____) ____-______ CELL: (____) ____-______

EMPLOYER: ______________________ ADDRESS:____

PLEASE ANSWER THE FOLLOWING YES OR NO & EXPLAIN "YES" ANSWERS:

1. Have you ever had any heart or lung trouble? NO YES___________________________
2. Have you ever had stomach, intestine, or liver trouble? NO YES___________________________
3. Have you ever been treated for a tumor or cancer? NO YES___________________________
4. Have you ever been diagnosed with arthritis? NO YES___________________________
5. Do you experience indigestion, nausea, or heartburn? NO YES___________________________
6. Do you often experience diarrhea or constipation? NO YES___________________________
7. Do you often get tired and run down? NO YES___________________________
8. Have you ever had high blood pressure? NO YES___________________________
9. Do you drink more than (2) cups of coffee per day? NO YES___________________________
10. Have you ever smoked? If YES - how long and how many packs per day NO YES___________________________
11. Are you taking any prescription drugs? NO YES___________________________
12. Are you allergic to any drugs? NO YES___________________________
13. Are you taking any nutritional supplements? NO YES___________________________
14. Does cancer, diabetes, or heart disease run in your family? NO YES___________________________
15. Have you ever had surgery? NO YES___________________________
16. Do you have more than (1) headache per week? NO YES___________________________
17. Have you ever had fainting spells or blackouts? NO YES___________________________
18. Have you ever had a stroke? NO YES___________________________
19. Have you ever been treated by another Chiropractor or Osteopath? NO YES___________________________
20. Have you ever been to a Physical Therapist? NO YES___________________________
21. Do you exercise regularly? NO YES___________________________
22. Have you had a physical in the past (2) years? NO YES___________________________
23. Do you drink alcohol? If Yes, how many drinks/week NO YES___________________________
24 Do you currently use recreational drugs? NO YES___________________________
25. **Men Only:** Do you have any trouble with your urine flow? NO YES___________________________
26. **Women Only:** Pregnant? Last menstrual period? NO YES___________________________

Who is your Primary Care Physician:______________________________________ Phone _________________________

Your Height:__________________ Your Weight: _______________________

Please be complete & specific:

Describe your symptoms that bring your here: ____

When did your problem start? __________________________ How did it start? __________________________________

Have you had this or similar problem before? ____

Have you consulted another doctor for this problem? Yes No Doctor's Name ________________________________

Have you had any tests, x-rays, etc performed? Yes No Where?____

(PLEASE TURN PAGE OVER)

NAME:____**DATE:**______________________ **PAGE 2**

How often do you have symptoms? (circle one) Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (0-25%)

On a pain scale of 1-10, how bad are your symptoms at their BEST and at their WORST? (circle one for each)
1 2 3 4 5 6 7 8 9 10
minimal unbearable

Describe your pain (check all that apply):__ sharp __dull ache __numbness __tingling __burning __stitch
__ shooting __ stabbing __nagging __tightness __pressure __weakness ___headache __dizziness

Does your pain affect your daily activities? YES NO How?____

Are you having difficulty: __ sitting __standing __ walking __sleeping __ changing positions

Do you feel best when: __ sitting __standing __walking ___lying down

Do your **ARMS/HANDS** or your **LEGS/FEET** feel **NUMB, TINGLE, PINS/NEEDLES,** or **PAIN.** (circle any that apply)

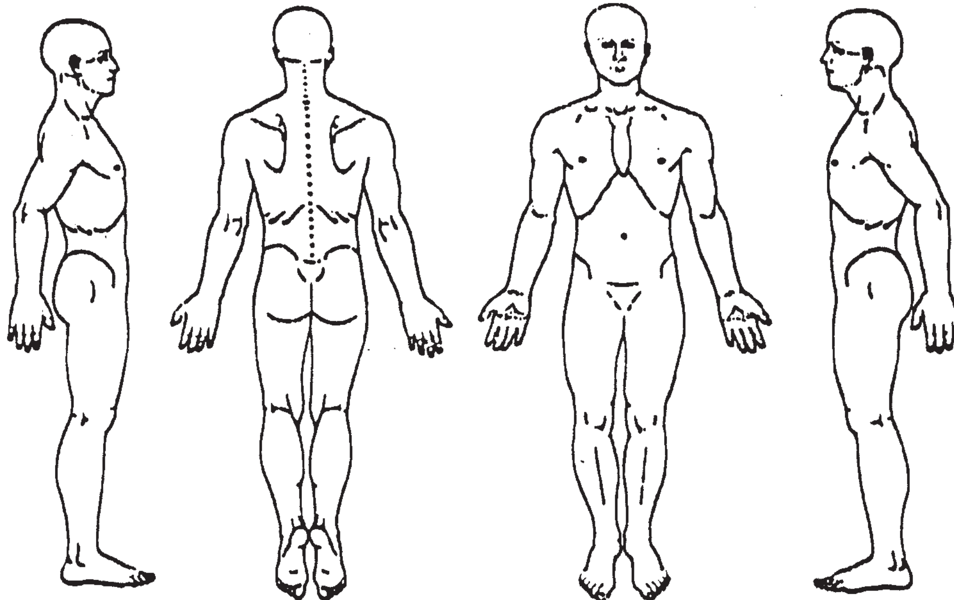
Is your injury work related? YES NO What is your occupation? ____________________ Are you working? YES NO

Have you had previous work related injuries or motor vehicle accident? YES NO Describe: ____________________________

What position do you normally sleep in? ____________________ How old is your mattress ______________________

Do you sleep in a water bed? YES NO

Please mark the areas of discomfort or pain on the fugures below using the symbol that best describes the feeling:
+ + + Sharp or stabbing pain 0 0 0 Pins and needles V V V Dull or aching / / / Numbness



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