



Lucas Chiropractic Center, S.C.
 12413 S. HARLEM AVENUE
 PALOS HEIGHTS, IL 60463
 708-361-5455 • Fax 708-361-2156

Patient Health History

Date: _____

Name: _____ Age: _____ Date of Birth: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): _____ (Work/Cell): _____ Marital Status: S M D W

Occupation: _____ Social Security Number: _____

Employer: _____ Insurance Company: _____

How did you hear about this office: _____ Referred by: _____

Past Chiropractic Care: Yes No When? _____ Doctor's Name: _____ Results: _____

Are your present problems due to an injury? Yes No On Job Auto Accident Personal Injury Other: _____

Has the accident been reported? Yes No To Employer Auto Carrier Other: _____

Are you now or have you ever been disabled? (Service or Work)? Yes No When? _____

Have you retained an attorney? Yes No Name & Address: _____

What is your current work status?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Full time, no restrictions | <input type="checkbox"/> Full time, restrictions | <input type="checkbox"/> Full time Homemaker | <input type="checkbox"/> Full time student |
| <input type="checkbox"/> Part time, no restrictions | <input type="checkbox"/> Part time, restrictions | <input type="checkbox"/> Retired | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Off work due to restrictions | <input type="checkbox"/> Other _____ | | |

Restrictions:

Off work: Yes No Previously From: _____ to _____

Light duty: Yes No Previously (If yes, what are/were your restrictions?) _____

Do/did you require outside help at home?

Yes No (If yes, what help do/did you need?) _____

List any accidents or falls and dates: Auto: _____ Recreation: _____

Sports: _____ Work Related: _____ Other: _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? Yes No Why? _____

Were you ever knocked unconscious? Yes No (If yes, please explain): _____

Have you ever had X-rays taken? Yes No When? _____ By Whom? _____

For what ailments were these X-rays made? _____

Do you wear orthotics or heel lifts? Yes No Fitted by whom? _____ When? _____

Do you suffer from any condition other than that for which you are now consulting us? Yes No _____

Are you presently taking any medication, prescription, over-the-counter, home remedies, vitamins, minerals, etc.?

(Please list) _____

OPERATIONS AND PROCEDURES

I have never had any operations or surgeries

DATE		DATE		DATE	
_____	Vaccinations	_____	Spinal Taps/Injections	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach

Other: _____

General Symptoms

Never Previously Presently Allergy (What) _____

Bronchitis

Chills (Constant)

Convulsions

Dizziness

Fainting

Fatigue

Headache

Loss of Sleep

Loss of Weight

Nervousness

Night Sweats

Numbness or Pain in arms/legs/hands

Wheezing

Gastro-Intestinal

Never Previously Presently Belching or Gas

Colon Trouble

Constipation

Diarrhea

Gall Bladder Trouble

Hemorrhoids (piles)

Jaundice

Liver Trouble

Nausea

Stomach Pain

Vomiting

Vomiting Blood

Heart Burn

Bloody Stools

Acid Reflux

Irritable Bowel

Eye/Ear Nose/Throat

Never Previously Presently Asthma

Deafness

Earache

Ear Discharge

Ear Noises

Thyroid Problems

Frequent Colds

Hay Fever

Nasal Obstruction

Nose Bleeds

Pain in Eyes

Poor Vision

Blurred Vision

Sinusitis

Sore Throats

Tonsillitis

Respiratory

Never Previously Presently Chest Pain

Chronic Cough

Difficulty Breathing

Spitting Blood

Spitting Phlegm

Genito-urinary

Bed Wetting

Blood in Urine

Frequent Urination

Inability to Control Urine

Kidney Infection

Kidney Stones

Painful Urination

Prostate Trouble

Muscles & Joints

Backache

Foot Trouble

Hernia

Pain Between Shoulders

Painful Tail Bone

Stiff Neck

Spinal Curvature

Swollen Joints

Tremors

Cardio-vascular

High Blood Pressure

Low Blood Pressure

Chest Pain

Heart Trouble

Poor Circulation

Rapid Heart

Slow Heart

Strokes

Swelling Ankles

Skin Or Allergies

Bruising Easily

Dryness

Eczema

Hives or Allergy

Itching

Sensitive Skin

Skin Eruptions

For Females Only

Cramps

Hot Flashes

Irregular Cycle

Painful Periods

Vaginal Discharge

Yes No Pregnant at this Time

_____ Last Pap Date

_____ Last Menstrual Cycle

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING DISEASES?

<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Measles
<input type="checkbox"/> Goiter	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Mumps	<input type="checkbox"/> Influenza	<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Polio	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Lumbago	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Eczema	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Cancer	<input type="checkbox"/> Venereal Disease	W HIV Positive

HABITS		EXERCISE	FAMILY HISTORY			
<input type="checkbox"/> Smoking	Packs/day: _____	<input type="checkbox"/> None	Diabetes	Kidney	Cancer	Back
<input type="checkbox"/> Drinking	Alcohol: (Cups/day) _____	<input type="checkbox"/> Moderate				
<input type="checkbox"/> Coffee	Cups/day: _____	<input type="checkbox"/> Daily	Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Soft Drink	Bottles or Cans/day: _____	Type: _____	Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Water	Cups/day: _____		Brother(s), # of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Sister(s), # of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient's/Guardian's Signature: _____ Date: _____