Linglestown Chiropractic · Dr. Ryan Semendinger · 4456 Oakhurst Blvd · Harrisburg, PA 17110

CONFIDENTIAL PATIENT HISTORY

Name ____ Date ______________

Address ______________________________ City ______________ State _____ ZIP ________

Phone _______________ Email ____________________________ DOB _________ Age ___

Occupation _______________________ Employer/School ____________________________

Marital Status ______________ Number of Children ______ How did you hear about us? ____________

What is your major complaint? ____

How did this pain begin? _________________________________ Have you had this before? Y N

How long have you had this pain? ____________________ Is the complaint: *improving* *worsening*

What type of pain is it? *Please circle all that apply.*

Achy	Loss of Feeling	Swelling
Burning	Numbness	Throbbing
Cramping	Sharpness	Tingling
Dull	Stiffness	Other ____________

Which activities aggravate your condition? *Please circle all that apply.*

Bathing	Exercising	Pushing	Twisting
Bending	Kneeling	Running	Walking
Cleaning	Leaning	Sitting	Other __________
Dressing	Lifting	Standing	None of the Above
Driving	Pulling	Stooping	

Which activities relieve your condition? *Please circle all that apply.*

Chiropractic Adjustment	Medication	Sitting
Heat	Movement	Standing
Ice	Resting	Other ____________

Does the pain, numbness, or tingling radiate into other areas of your body? **NO** **YES** *(Circle areas)*

Please complete other side

Abdomen	Head	Shoulders
Arms	Hips	Sternum
Chest	Legs	Other ___________
Feet	Mid Back	
Hands	Neck	

Rate the severity of pain (0 no pain to 10 severe pain): ___________

What other complaints have you experienced in the past 3 months? *Please circle all that apply.*

Ankle/Foot Pain	Carpal Tunnel Syndrome	Leg Pain	Shoulder Blade Pain
Arm Pain	Cold Feet	Lower Back Pain	Shoulder Pain
Arthritis (spine)	Cold Hands	Mid Back Pain	Tailbone Pain
Arthritis (other)	Dizziness	Muscle Spasms	Upper Back Pain
Bulging Discs	Headaches	Neck Pain	Other ______________
Buttock Pain	Knee Pain	Pinched Nerves	None of the Above

What other health conditions do you have? *Please circle all that apply.*

Anxiety	Epilepsy	Multiple Sclerosis	Thyroid Problems
Bleeding Disorder	Heart Disease	Osteoporosis	Tremors
Cancer	High Cholesterol	Parkinson’s	Tumors/Growths
Depression	Kidney Disease	Rheumatoid Arthritis	Other ______________
Diabetes	Lung Disease	Stroke	None of the Above

What is your smoking status? *Please circle one.*

Never Smoker   Former Smoker   Current Occasional   Current Daily

Are you currently pregnant? **YES** **NO**

Have you ever seen a Chiropractor? **YES** **NO**   Date of last visit: ____________________________

Patient’s Signature ____ **Date** ___________________