



# Alexander & Grenon CHIROPRACTIC CENTER, P.C.

PERSONAL HISTORY UPDATE

Dr. James D. Grenon  
Dr. Daniel L. Ruddy

## PATIENT IDENTITY

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

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

Home Phone:( ) \_\_\_\_\_ Work:( ) \_\_\_\_\_ Cell:( ) \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status: M / S / W / D / Sep. Emergency Contact: \_\_\_\_\_ Phone:( ) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Location: \_\_\_\_\_

Family M.D. (PCP) \_\_\_\_\_ Address: \_\_\_\_\_ Phone:( ) \_\_\_\_\_

Age: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ Is there irremovable metal in your body? ( ) Y ( ) N Where? \_\_\_\_\_

## PATIENT INSURANCE

1.) **Primary Insurance Company:** \_\_\_\_\_

2.) **Primary Insurance** is under: ( ) **Self** (go to #3) ( ) **Spouse** (go to A-D) ( ) **Parent** (go to A-D) ( ) **Other** (go to A-D)

A.) **Primary Insured** (Policy Holder's Name): \_\_\_\_\_

B.) **Primary Insured Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

C.) **Primary Insured SS#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

D.) **Primary Insured Place of Employment:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone:( ) \_\_\_\_\_

3.) Do you have a **Second Insurance**? ( ) Yes ( ) No Name of Company? \_\_\_\_\_

ID #: \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_

4.) Has your health insurance company or coverage **changed** over the last year? ( ) Yes ( ) No

5.) Have you seen a **Chiropractor** or **Physical Therapist** during the past year? ( ) Yes ( ) No

**PLEASE PROVIDE THE FOLLOWING INFO. REGARDING YOUR RECENT HEALTH HISTORY**

My Present Symptoms Are: \_\_\_\_\_  
 Recent Falls: \_\_\_\_\_ Recent Accidents: \_\_\_\_\_  
 Recent Surgery: \_\_\_\_\_ Current Medications: \_\_\_\_\_  
 Last visit to our office: \_\_\_\_\_ Last Physical: \_\_\_\_\_  
 Since the last time I saw you, I have been treated by: \_\_\_\_\_  
 For: \_\_\_\_\_

**CHECK ANY OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:**

<p><b>MUSCULOSKELETAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Muscle Spasms or Cramps</li> <li><input type="checkbox"/> Low back pain</li> <li><input type="checkbox"/> Leg pain</li> <li><input type="checkbox"/> Hip pain</li> <li><input type="checkbox"/> Pain between shoulders</li> <li><input type="checkbox"/> Neck pain</li> <li><input type="checkbox"/> Arm pain</li> <li><input type="checkbox"/> Joint pain / Stiffness</li> <li><input type="checkbox"/> Walking problems</li> <li><input type="checkbox"/> Difficult Chewing/Clicking Jaw</li> <li><input type="checkbox"/> Weakness in Arms or Legs</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Joint Swelling</li> </ul>	<p><b>GENERAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Allergies</li> <li><input type="checkbox"/> Loss of Sleep</li> <li><input type="checkbox"/> Fever</li> </ul>	<p><b>MALE / FEMALE</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Genital Herpes</li> <li><input type="checkbox"/> Sexual Dysfunction</li> <li><input type="checkbox"/> Prostate problems</li> </ul> <p><b>FEMALES ONLY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Menstrual irregularity</li> <li><input type="checkbox"/> Menstrual Cramping</li> <li><input type="checkbox"/> Vaginal pain / Infections</li> <li><input type="checkbox"/> Breast pain / Lumps</li> <li><input type="checkbox"/> Bleeding or Discharge</li> </ul> <p>Date of last Period? _____                  Pregnant? Y / N / Maybe</p>																																									
<p><b>NERVOUS SYSTEM</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Numbness / Tingling</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Forgetfulness</li> <li><input type="checkbox"/> Confusion / Depression</li> <li><input type="checkbox"/> Fainting</li> <li><input type="checkbox"/> Convulsions</li> <li><input type="checkbox"/> Cold Extremities</li> <li><input type="checkbox"/> Headaches / Migraines</li> <li><input type="checkbox"/> Nervousness</li> </ul>	<p><b>CARDIO-VASCULAR-RESP.</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Chest pain</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Blood Pressure problems</li> <li><input type="checkbox"/> Irregular Heartbeat</li> <li><input type="checkbox"/> Heart problems</li> <li><input type="checkbox"/> Lung problems / Congestion</li> <li><input type="checkbox"/> Varicose veins</li> <li><input type="checkbox"/> Ankle Swelling</li> <li><input type="checkbox"/> Fatigue</li> </ul>	<p><b>EXERCISE</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None / Occasional</li> <li><input type="checkbox"/> Moderate (2-3 times / week)</li> <li><input type="checkbox"/> Regular (4-7 times / week)</li> </ul>																																									
<p><b>EAR-EYE-NOSE-THROAT</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Loss of Taste</li> <li><input type="checkbox"/> Vision problems</li> <li><input type="checkbox"/> Dental problems</li> <li><input type="checkbox"/> Sore throat</li> <li><input type="checkbox"/> Ear aches</li> <li><input type="checkbox"/> Hearing difficulty</li> <li><input type="checkbox"/> Stuffed nose</li> <li><input type="checkbox"/> Loss of Smell</li> <li><input type="checkbox"/> Frequent colds</li> <li><input type="checkbox"/> Sinus problems</li> <li><input type="checkbox"/> Ringing in Ears</li> </ul>	<p><b>GASTRO-INTESTINAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Poor / Excessive Appetite</li> <li><input type="checkbox"/> Excessive Thirst</li> <li><input type="checkbox"/> Frequent Nausea</li> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Liver trouble</li> <li><input type="checkbox"/> Gallbladder problems</li> <li><input type="checkbox"/> Weight trouble</li> <li><input type="checkbox"/> Abdominal Cramps</li> <li><input type="checkbox"/> Gas / Bloating after meals</li> <li><input type="checkbox"/> Heartburn</li> <li><input type="checkbox"/> Black / Bloody stool</li> <li><input type="checkbox"/> Colitis</li> </ul>	<p><b>HABITS</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Smoking ____ packs / day</li> <li><input type="checkbox"/> Alcohol ____ times / week</li> <li><input type="checkbox"/> Coffee ____ cups / day</li> </ul>																																									
			<p><b>FAMILY HISTORY</b></p> <p><b>Place an "X" in the Appropriate Box</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Mom</th> <th>Dad</th> <th>Sister</th> <th>Brother</th> </tr> </thead> <tbody> <tr> <td><b>Back Trouble</b></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>Diabetes</b></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>Heart</b></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>Kidney</b></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>Cancer</b></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>Migraine/Headache</b></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>Other</b></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Mom	Dad	Sister	Brother	<b>Back Trouble</b>					<b>Diabetes</b>					<b>Heart</b>					<b>Kidney</b>					<b>Cancer</b>					<b>Migraine/Headache</b>					<b>Other</b>				
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**I certify that all information I have provided within these sections is truthful and accurate to the best of my knowledge.**

Patient's Signature: X Printed Name: \_\_\_\_\_ Date: / /

