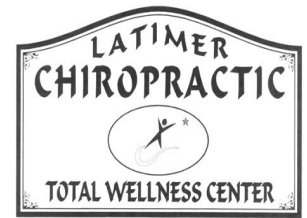


**PAMELA G. LATIMER, D.C.**



**PATIENT HEALTH HISTORY**

**PLEASE ANSWER ALL QUESTIONS FULLY TO HELP THIS OFFICE SERVE YOU BETTER**

NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_

MAILING ADD \_\_\_\_\_ STREET ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ AGE OF CHILD \_\_\_\_\_

YOUR OCCUPATION \_\_\_\_\_ NAME OF COMPANY \_\_\_\_\_  
If retired, what did you do?

WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

MARTIAL STATUS S M W Sep SPOUSES NAME \_\_\_\_\_  
SPOUSES OCCUP \_\_\_\_\_ NAME OF COMPANY \_\_\_\_\_

WE HAVE INFORMATION TO GIVE YOU TO HELP YOU UNDERSTAND YOUR CONDITION AND HEAL MORE QUICKLY. DO YOU PREFER REGULAR MAIL OR EMAIL?  
YOUR E-MAIL ADDRESS \_\_\_\_\_

EMERGENCY CONTACT name and phone number \_\_\_\_\_

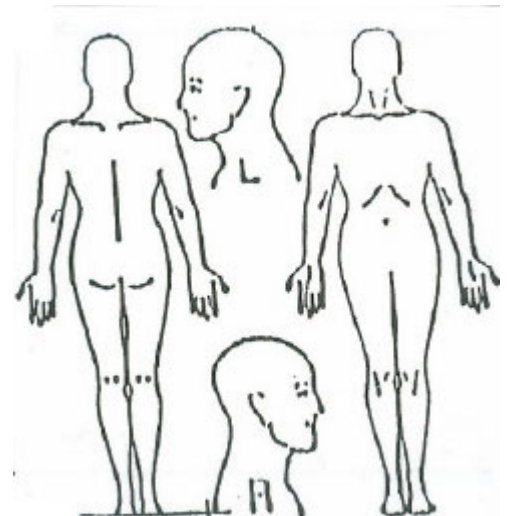
DO YOU WEAR A SEAT BELT REGULARLY? Yes \_\_\_ No \_\_\_ Sometimes \_\_\_\_\_  
WHO CAN WE THANK FOR REFERRING YOU TO THIS OFFICE? \_\_\_\_\_

WHO IS YOUR LOCAL DOCTOR? \_\_\_\_\_ LAST EXAM DATE \_\_\_\_\_  
TREATMENTS IN THE LAST YEAR? \_\_\_\_\_

WHAT CAN WE HELP YOU WITH? \_\_\_\_\_

MARK THE BODY PARTS IN DISCOMFORT, USING THE SYMBOLS BELOW DESCRIBE WHAT YOU ARE FEELING

- numbness xxxxxx
- pins & needles.....
- burning 0000000
- aching ^^^^^^^
- stabbing //////////////



MARK THE LEVEL OF PAIN YOU ARE IN **1**-----**10**  
Less pain Most pain

HOW AND WHEN DID IT FIRST DEVELOP? \_\_\_\_\_

TREATED FOR THIS CONDITION IN THE PAST? \_\_\_\_\_

WHEN \_\_\_\_\_ BY WHOM \_\_\_\_\_

WHAT WERE THE RESULTS? \_\_\_\_\_

HOME TREATMENT FOR THIS? Ice----Heat-----exercises----Medications \_\_\_\_\_

WHAT IMPROVES IT? \_\_\_\_\_

IS THIS CONDITION GETTING BETTER \_\_\_ WORSE \_\_\_ STAYING THE SAME \_\_\_

DO YOU HAVE TROUBLE from the pain (PLEASE CIRCLE) SLEEPING—SITTING—BENDING---LIFTING

RISING FROM CHAIR--BED---SQUATTING---REACHING ---HOLDING OBJECTS--(OTHER) \_\_\_\_\_

XRAYS, MRI, BONE DENSITY TESTS in the last 10 years, facility, body area and approx. date

\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS you take and their purpose? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

VITAMINS YOU TAKE? \_\_\_\_\_

CIRCLE ANY THAT APPLY OVER YOUR ENTIRE LIFE AND THE GENERAL DATE

AUTO ACCIDENTS \_\_\_\_\_ TRAUMA/FALLS \_\_\_\_\_

MAJOR SURGERIES \_\_\_\_\_ BROKEN BONES \_\_\_\_\_

CONTACT SPORTS \_\_\_\_\_ SERIOUS ILLNESS \_\_\_\_\_

SMOKER \_\_\_\_\_ ALCOHOL \_\_\_\_\_

HEAVY LIFING JOBS \_\_\_\_\_ OSTEOPOROSIS DIAGNOSIS \_\_\_\_\_

RECENT FEVER \_\_\_\_\_ STEROID TREATMENTS \_\_\_\_\_

UNEXPLAINED WEIGHT LOSS \_\_\_\_\_ FAINTING \_\_\_\_\_

I give permission for the doctor to examine me and do all tests necessary, for my treatment at Latimer Chiropractic. All fees are payable at the time the exam and treatment are received, unless arrangements are made in advance with the doctor

PATIENT  
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

CHILD HISTORY INFO

BIRTH INFO: ANY DIFFICULTIES OR DELAYS DURING LABOR? \_\_\_\_\_

BIRTH WEIGHT \_\_\_\_\_ LENGTH \_\_\_\_\_

DIET INFO: BREAKFAST \_\_\_\_\_ LUNCH \_\_\_\_\_ DINNER \_\_\_\_\_

ANY DIGESTIVE SKIN BEHAVIORAL SYMPTOMS? \_\_\_\_\_

I hereby authorize Pamela G. Latimer, D.C. and whomever she may designate to administer care as is deemed necessary to my son/daughter/ward.

**PARENTS SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**4/09**