UPDATED PATIENT HISTORY

Please fill in your name and other demographic information that may need to be changed or updated in our files

Dr. Michael J. Cleaver, D.C.

Today's Date (MM/DD/YYYY) ◯ **I have NEW contact information**

You Last Name **Your First Name** **Your Middle Name (or Initial)**

Please select one:

- ◯ **Progress evaluation** – I've been under active care and this is a periodic reevaluation
- ◯ **Maintenance patient** – I'm under maintenance care with a new or returning health issue
- ◯ **New Condition** – I've been under care and a new or returning condition has emerged
- ◯ **Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue

Please describe your Primary Complaint below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint

The primary symptom that prompted me to seek care today is: _____

And are the result of:

◯ An accident or injury
◯ Work ◯ Auto ◯ Other:_____

◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other: ___

Onset (when did you first notice your current symptoms?)

Prior interventions (what have you done to relieve the symptoms?)

◯ Prescription medication
◯ Over the counter drugs
◯ homeopathic remedies
◯ Physical therapy
◯ Acupuncture
◯ Surgery
◯ Chiropractic
◯ Massage
◯ Ice
Heat
Other: _____

Secondary Complaint

The primary symptom that prompted me to seek care today is: _____

And are the result of:

◯ An accident or injury
◯ Work ◯ Auto ◯ Other:_____

◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other: ___

Onset (when did you first notice your current symptoms?)

Prior interventions (what have you done to relieve the symptoms?)

◯ Prescription medication
◯ Over the counter drugs
◯ homeopathic remedies
◯ Physical therapy
◯ Acupuncture
◯ Surgery
◯ Chiropractic
◯ Massage
◯ Ice
Heat
Other: _____

Additional Complaint

The primary symptom that prompted me to seek care today is: _____

And are the result of:

◯ An accident or injury
◯ Work ◯ Auto ◯ Other:_____

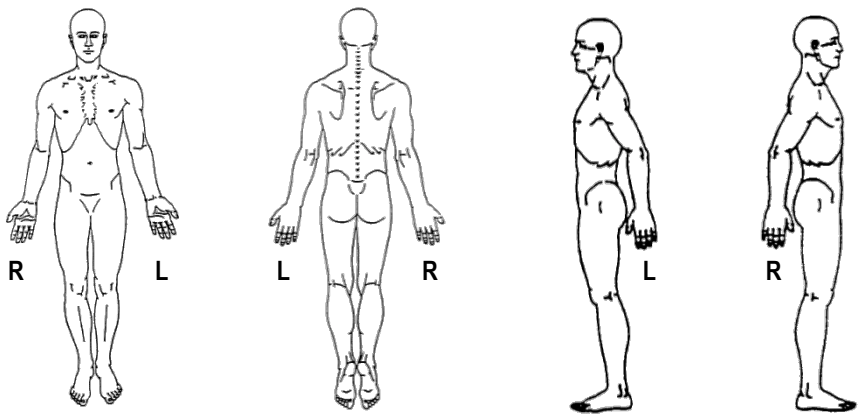
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other: ___

Onset (when did you first notice your current symptoms?)

Prior interventions (what have you done to relieve the symptoms?)

◯ Prescription medication
◯ Over the counter drugs
◯ homeopathic remedies
◯ Physical therapy
◯ Acupuncture
◯ Surgery
◯ Chiropractic
◯ Massage
◯ Ice
Heat
Other: _____

Location (Where does it hurt?)
Circle the area(s) on the illustrations
"O" for current condition
"X" for conditions experienced in the past



UPDATED PATIENT HISTORY, *Continued...*

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Dr. Michael J. Cleaver, D.C.

1. Review of systems (identify any changes since your most recent evaluation with us):

	Worse	No Change	Improved
a. Musculoskeletal System – such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	○	○	○
b. Neurological System – such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	○	○	○
c. Cardiovascular System – such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	○	○	○
d. Respiratory System – such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	○	○	○
e. Digestive System – such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	○	○	○
f. Sensory System – such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	○	○	○
g. Skin System – such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	○	○	○
h. Endocrine System – such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	○	○	○
i. Genitourinary System – such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	○	○	○
j. Constitutional System – such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	○	○	○

2. Illnesses, operations, injuries or treatments since your most recent evaluation with us: _____

_____

_____

3. Medications (Please list all prescriptions and over-the-counter): _____

_____

_____

4. Social History (Tell Dr. Cleaver about your health habits and stress levels)

Alcohol use	○ Daily ○ Weekly	How much? _____	Prayer or meditation?	○ Yes ○ No	
Coffee use	○ Daily ○ Weekly	How much? _____	Job pressures/stress?	○ Yes ○ No	
Tobacco use	○ Daily ○ Weekly	How much? _____	Financial peace?	○ Yes ○ No	
Exercising	○ Daily ○ Weekly	How much? _____	Vaccinated?	○ Yes ○ No	
Pain relievers	○ Daily ○ Weekly	How much? _____	Mercury fillings?	○ Yes ○ No	
Soft drinks	○ Daily ○ Weekly	How much? _____	Recreational drugs?	○ Yes ○ No	
Water intake	○ Daily ○ Weekly	How much? _____			

Hobbies: _____

5. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○	Grocery shopping	○	○	○	○
Rising out of chair	○	○	○	○	Household chores	○	○	○	○
Standing	○	○	○	○	Lifting objects	○	○	○	○
Walking	○	○	○	○	Reaching overhead	○	○	○	○
Lying down	○	○	○	○	Showering or bathing	○	○	○	○
Bending over	○	○	○	○	Dressing myself	○	○	○	○
Climbing stairs	○	○	○	○	Love Life	○	○	○	○
Using a computer	○	○	○	○	Getting to sleep	○	○	○	○
Getting in/out of car	○	○	○	○	Staying asleep	○	○	○	○
Driving a car	○	○	○	○	Concentrating	○	○	○	○
Looking over shoulder	○	○	○	○	Exercising	○	○	○	○
Caring for family	○	○	○	○	Yard work	○	○	○	○

6. Is there anything else Dr. Cleaver should know about your current condition, your progress or ways your current condition is affecting your life? _____