WOODWARD CHIROPRACTIC
Accident and Injury Care
MARK WOODWARD, D.C.
1048 US 31-W Bypass
Bowling Green, KY 42101
(270) 781-5644/ Fax (270) 781-4401

CAUTION LIST/PATIENT HISTORY

Patient Name: _____ File: _____

Date: _____ Date of Birth: _____ Interviewer: _____

Do you have chest pain?	Yes ___ No ___
Do you have any change or loss of control in bowel or bladder habits?	Yes ___ No ___
Do you have a sore that does not heal?	Yes ___ No ___
Do you have any unusual bleeding or discharge?	Yes ___ No ___
Do you have any thickening in your breasts or elsewhere?	Yes ___ No ___
Do you have indigestion or difficulty in swallowing?	Yes ___ No ___
Do you have a change in any wart or mole?	Yes ___ No ___
Do you have a nagging cough or hoarseness?	Yes ___ No ___
Do you have headaches for hours or days?	Yes ___ No ___
Do you have night sweats?	Yes ___ No ___
Do you have pain in neck, jaw, or face?	Yes ___ No ___
Do you have a drooping eyelid or any change in your pupils?	Yes ___ No ___
Do you have vertigo (dizziness)?	Yes ___ No ___
Do you have double vision?	Yes ___ No ___
Do you have nausea or vomiting?	Yes ___ No ___
Do you have any slurred speech?	Yes ___ No ___
Do you have any ringing in your ears?	Yes ___ No ___
Do you pass out easily (faint) or have you lost consciousness recently?	Yes ___ No ___
Do you take any form of birth control?	Yes ___ No ___
Have you ever had cancer?	Yes ___ No ___
Does your pain ever wake you from a sound sleep?	Yes ___ No ___
Are you losing weight right now without trying?	Yes ___ No ___
Are you coughing up blood or noticing it in your stool or urine?	Yes ___ No ___
What was the date of onset of your menses?	_____
Are you seeing **ANY** other doctor now for **ANY** REASON?	Yes ___ No ___

Note:

_____

Are you taking any over-the-counter drugs? Yes ___ No ___

Please indicate type (aspirin, etc.)

_____

What prescription medication are you taking, if any?

- ☐ High blood pressure medication
- ☐ Blood thinners
- ☐ Other:

_____

_____

- ☐ List allergies or adverse reactions to medications:

_____

Family Physician's Name: _____

Please send a report to my family physician. Yes ____ No ____

Have you had any cosmetic surgery, breast implants, etc.? Yes ____ No ____ Year _____

Have you had any surgery to replace joints such as hip, knee, shoulder, etc.? Yes ____ No ____ Year _____

Social History

Level of education: _____ High School _____ College Degree _____Post-Grad

Marital Status: M/S _____ Number of Children & Ages _____

Smoker: Yes _____ No _____ If yes, how much? _____

Alcohol: Yes _____ No_____ If yes, how much? _____

Recreational Drug Use: Yes _____ No _____ If yes, what & how often? _____

Family History

Did your mother or father have any of the following?

Put an "M" for mother, a "F" for father, or "B" for both.

_____ High Blood Pressure
_____ Heart Attack
_____ Emphysema
_____ Seizures-Convulsions
_____ HIV Positive
_____ Asthma
_____ Diabetes
_____ Kidney Disease
_____ Pacemaker
_____ Scoliosis
_____ Ulcer or Stomach Problems
_____ Stroke
_____ Rheumatic Arthritis
_____ Mental Illness/Nervous Condition
_____ Thyroid Disease
_____ Circulation Problems
_____ Cancer (Type: _____)
_____ Osteoporosis
_____ Liver Trouble

Comments:

_____

_____

_____

_____

_____

_____

Date: _____ Patient's Signature: _____

BNM/July 2015