



Office Use Only: \_\_\_\_\_

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### Confidential Health History

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_' - \_\_\_\_\_" Weight \_\_\_\_\_ lbs

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

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

May we thank who referred you? \_\_\_\_\_  Sign  Internet  Yellow pages  Hotel

Who is your primary medical doctor/health care provider? \_\_\_\_\_

#### Please List Your Problem(s)

#### Rate Your Pain (Circle least & worst)

1.) \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

My Pain is →  Dull,  Achy,  Numb,  Sharp,  Shooting,  Spasm,  Burning,  Tingling,  Throbbing,  Weakness

I feel it →  Constantly (> 76% of day),  Frequently (51-75%),  Occasionally (26-50%),  Intermittently (< 25%) of the time.

2.) \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

My Pain is →  Dull,  Achy,  Numb,  Sharp,  Shooting,  Spasm,  Burning,  Tingling,  Throbbing,  Weakness

I feel it →  Constantly (> 76% of day),  Frequently (51-75%),  Occasionally (26-50%),  Intermittently (< 25%) of the time.

WHEN did this begin? \_\_\_\_\_

WHAT caused it? \_\_\_\_\_

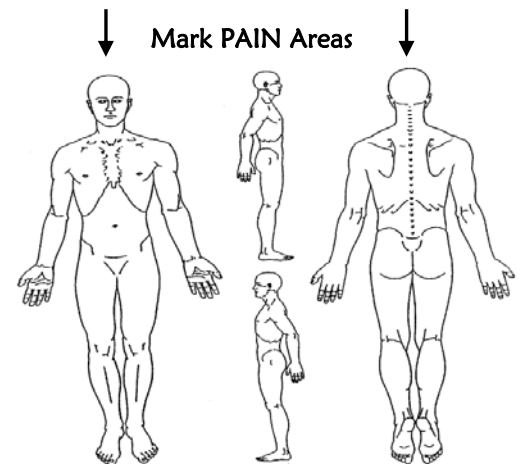
Have you ever had this before?

No (First time),  Yes;  once before,  several times,  many times

Is it getting:  Better  Same  Worse

Does the Pain RADIATE?  No /  Yes, to my  Head  Shoulder  Arm

Buttock  Thigh  Leg  Foot  other \_\_\_\_\_



What makes it feel BETTER?  Nothing/  sitting  standing  walking  movement  ice  heat  exercise  massage

Drugs (list)  other (explain)

What makes it WORSE?  lying down  sitting  standing  walking  movement  ice  heat  exercise  Other (explain)

Is it Worse:  morning  evening  at night  always the same  Other

Have you had any Treatment for this Current Problem?  No/ Yes →  medical  chiropractic  physical therapy  massage

Acupuncture  ice  heat  drugs \_\_\_\_\_ Did it help?  Yes/ No

Have you ever had Chiropractic Care before?  No/ Yes →  Same Problem,  Different (explain)

