IN GOOD HANDS CHIROPRACTIC, PLLC

Dr. Renee Tetreault
16 Elm Street, Wolfeboro, NH 03894
603-217-2118

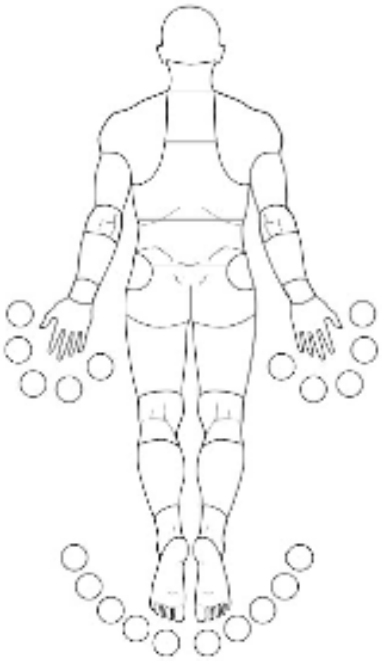
Medical History Information

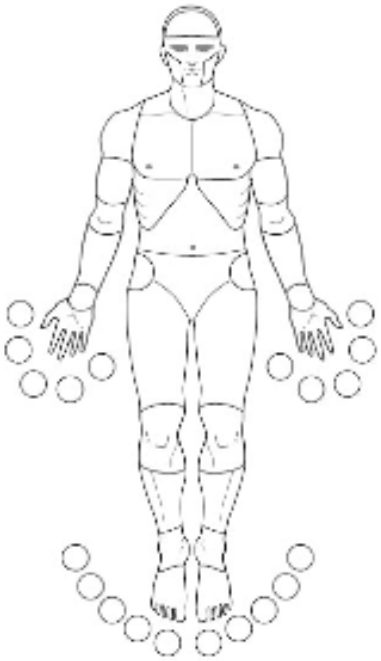
Date: _____

Last Name:	First Name:	Middle Init:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.
☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Married Spouse's Name:				
Email:		Birth date:	Age:	Sex:
Address:	City:	State:	Zip:	
Social Sec. No:	Home Phone:	Cell Phone:		
Occupation:	Employer:	Work No:		
Emergency Contact:	Phone No:	Relationship:		
Have you ever been treated by a chiropractor?: ☐ No ☐ Yes, Name of Doctor:				
Are you currently taking any medications? ☐ No ☐ Yes, Please list them:				
Have you ever had surgery?: ☐ No ☐ Yes, Reason for Surgery and date:				

Please indicated the current complaints you are experiencing by circling from 1-24 and marking the areas on the images below

1. Headaches
2. Neck
3. Upper Back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen Pelvis/Groin





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Date of most recent episode:

Dates of previous episodes:

Describe events or time of day,
which seem to make this condition better:

Describe events or time of day, which seem to
make this condition worse:

Have you experienced other physical traumas? YES NO

If so, please describe:

Date/Description: _____
Date/Description: _____

What other doctors have you seen for your present condition?
Name(s): Date: _____

Progress: Better_____ Worse_____ Same_____

Personal Habits:

Rate your overall diet:

Very good ___ Good ___ Fair ___ Poor___ Very poor___

Tobacco YES NO If yes, how much _____ how often _____

Alcohol YES NO If yes, how much _____ how often _____

Coffee YES NO If yes, how much _____ how often _____

Sleep: Average number of hours per night:

Quality of sleep: Good_____ Fair_____ Poor _____

Exercise: YES NO If yes, how much? how often?_____

Type of exercise:

Date of last chiropractic adjustment:

Current stress level:

Very High ____ High ____ Moderate ____ Low____ Very Low ____

Female History:

Date of last menstrual cycle:_____
Regular _____ Irregular _____

Are you taking birth control? YES NO

Which type? _____

Are you pregnant at this time? YES NO

(If Yes please answer the following questions)

Expected due date: _____

Have you had any previous pregnancies? YES NO

Of those, were any cesareans? YES NO
How many? _____

Did you have any health complications during
previous pregnancies? If so explain:

_____

_____

_____

_____

Additional Comments: