

Name _____ Date _____
 Address _____ State _____ Zip _____
 Home phone _____ Cell Phone _____ Work Phone _____
 Email address _____ Sex M/F Age _____
 DOB _____ SS# _____ Marital Status/ S M D W
 Occupation _____ Employer _____
 Work Address _____
 If applicable:
 Parents/Legal Guardians Name _____
 Address _____
 Home phone _____ Work Phone _____
 No. of Children _____
 How did you hear about our office? _____

Main Complaint

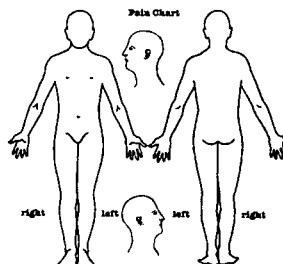
1. What is your major symptom? _____
 2. What does this prevent you from doing or enjoying? _____
 3. What is your treatment goal? _____
 4. If this is a recurrence, when was the first time you noticed the problem? _____
 5. How did it originally occur? _____
 6. Has it become worse recently? Yes _____ No _____ Same _____ Gradually Worse _____
 If yes, when and how? _____
 7. How frequent is the condition? Constant _____ Daily _____ Intermittent _____ Night Only _____
 8. How long does it last? All Day _____ Few Hours _____ Minutes _____
 9. How many days have you lost work due to these symptoms? _____
 10. Are there any other conditions or symptoms that may be related to your major symptoms Yes _____ No _____ If yes, describe _____
 11. Are there other unrelated health problems? Yes _____ No _____ If yes, describe _____
 Describe the pain: Sharp _____ Dull _____ Numbness _____ Tingling _____ Aching _____ Burning _____ Stabbing _____
 Other _____
 12. Is there anything you can do to relieve the problem? Yes _____ No _____ If yes, describe _____
 If no, what have you tried to do that has not helped? _____
 13. What makes the problem worse? Standing _____ Sitting _____ Lying _____ Bending _____ Lifting _____ Twisting _____ Other _____
 14. Have you had any broken bones? Yes _____ No _____ If yes, please list and give dates _____
 15. List any major accidents you have had other than those that might be mentioned above: _____
 16. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? _____
 17. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes _____ No _____ Uncertain _____
- Remarks: _____

No Pain

Unbearable Pain

Please place an "X" on the line above to indicate level of problem.

Show area(s) of pain or unusual feeling, pain or discomfort.



Past History

Past Chiropractic care / doctor's name _____
Family physician _____ Medications _____
Surgeries / dates _____
Illness / abnormalities _____
Previous Injuries & accidents / dates _____

Do you have difficulty with any of the following?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bladder Trouble |
| <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Menstrual cramps & pain |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Anemia | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Light bothers eye | <input type="checkbox"/> Nervous stomach | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Asthma/allergies | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Grating in neck | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Tightness in throat | <input type="checkbox"/> Tightness of shoulder muscle | <input type="checkbox"/> Nerves & nervousness | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Inflammation of throat | <input type="checkbox"/> Neuritis in shoulders & arms | <input type="checkbox"/> Inner tension | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Pins & needles in hands | <input type="checkbox"/> Irritability | <input type="checkbox"/> Slipped disk |
| <input type="checkbox"/> Face flushed | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Pinched nerves in back |
| <input type="checkbox"/> Twitching of face | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Pins & needles in legs |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart pain | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> Pains in legs & feet |
| <input type="checkbox"/> Head feels too heavy | <input type="checkbox"/> Heart palpation | <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Weight loss | | |

Family Medical History

Breast cancer	Other cancers	Cardiovascular disease	Stroke
Osteoporosis	Alcoholism	Mental illness/Depression	Obesity
Alzheimer's	Diabetes	Arthritis	Allergies

Please place an "F" for father or father's side or "M" for mother's side of the family in front of anything you circled in this section above.

Lifestyle and Diet

Rate your current level of stress on a scale of 1 to 10 (1=low): 1 2 3 4 5 6 7 8 9 10

What are the major causes? Work Family Finances Relationships Emotions
Other _____

I eat the following: Sweets Sodas/Pop Ice cream Fried foods
Cereals Legumes Fruits Vegetables

List your 4 favorite foods: _____

This applies to me: Diet frequently Skip meals Dine out regularly

Eat (0 1 2 3 4 5 6 more) meals a day

When do you eat? Morning, Noon, Night, Constantly snacking

Do you:

-use tobacco? YES or NO If yes, how much daily? _____
If no, did you ever? YES or NO if yes how long? _____

-Are you exposed to second hand smoke YES or NO If yes, how much daily? _____
If no, did you ever? YES or NO if yes how much? _____

-drink coffee? YES or NO If yes, how much daily? _____
If no, did you ever? YES or NO if yes how much? _____
Is it - strong mild decaf?

-eat chocolate? YES or NO If yes, how much daily? _____

-drink alcohol? YES or NO If yes, how many ounces a day/ week? _____
If no, did you ever? YES or NO if yes how much? _____
How long did you drink before you stopped? _____

-restrict your intake or avoid completely:
Fiber Salt Sugar Fat
Dairy products Animals protein All animal foods

Exercise

Exercise weekly? YES or NO If yes, how many times per week? _____