

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Sex M F Social Security Number: _____

Employed by: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status: M S D W Spouse's Name: _____ Children? Yes No Ages: _____

In case of emergency, please notify: _____ Phone: _____

Whom can we thank for referring you to our office? _____   

Advertisement Mailing Ins.Co. web Site The web, *what site?* _____ Other _____

If you are accepted for care, who is responsible for your bill? Self Spouse Parent

Workers Comp Auto accident / no-fault insurance Personal injury Medicare

Health Insurance Co. Name _____ Other _____

Why This Form Is Important:

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Your Early Years: (birth to 17yrs) *Current research has shown that many of the health challenges that occur in our adult life have their beginnings during our childhood years, some starting as early as birth.*

	Yes	No	Unsure		Yes	No	Unsure
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	As a child, did you receive regular chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you active in youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did you have any surgery as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you wear braces?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did you use any medications (antibiotics, inhalers, aspirin, etc.) on an on-going basis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of most resent auto accident / bad fall or injury							

Adult Years: (18+yrs)

	Yes	No		Yes	No
Did/ do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Did/ do you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>
Did/ do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Did/ do you participate in any extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	On a scale from 1-10 describe your stress level. (1=none/ 10 Extreme)	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Occupational 1 2 3 4 5 6 7 8 9 10		
			Personal 1 2 3 4 5 6 7 8 9 10		

Do you?	Yes	No
Floss daily:	<input type="checkbox"/>	<input type="checkbox"/>
Belong to health club:	<input type="checkbox"/>	<input type="checkbox"/>
Take vitamins:	<input type="checkbox"/>	<input type="checkbox"/>
Drink bottled water:	<input type="checkbox"/>	<input type="checkbox"/>
Describe your:		
Diet	Excellent	Good
Exercise	Excellent	Good
Sleep	Excellent	Good
General	Excellent	Good
Health	Excellent	Good

Reasons for consulting office: Please briefly describe the *chief area of complaint* ****If you have no symptoms or complaints and are interested in Wellness services, please let us know.**

Intensity Scale-1=low; 10=unbearable

1. _____	for how long _____	1 2 3 4 5 6 7 8 9 10
2. _____	for how long _____	1 2 3 4 5 6 7 8 9 10
3. _____	for how long _____	1 2 3 4 5 6 7 8 9 10

How often is the pain present? Intermittent (25% or less) Occasional (26-50%) Frequent (51-80%) Constant (81-100%)

Since your problem began, is your pain? Getting better Staying the same Getting worse

How did your problem begin? Auto accident Work related Other type of accident Gradual Onset

Sudden Onset No Specific reason Please explain: _____

What makes it worse? Please check all that apply:

- Walking Standing Sitting Stairs Driving Working Moving/Exercise Sneezing/Coughing Other: _____

Medications currently taking (OTC/Prescription): _____

Were you treated for this condition previously? Yes No If yes, by whom? Chiropractor MD Physical Therapist

Other _____ List dates, types of treatments and results: _____

Does your problem affect your ability to work or affect your routine daily activities? No effect Limited restrictions but can function Needs some assistance with daily activities Cannot work Cannot function without assistance Totally disabled

List all Surgeries: _____

Previous Chiropractor: Yes No Dr. _____ Time under care _____ Last Visit _____

Reason for interrupting care: _____

Other Doctors seen for this problem: MD/specialist _____ Physical Therapist Other _____

List dates, types of treatments and results: _____

Check off any of the following symptoms you have ever had even if you think they are not related to your problem:

MUSCULO-SKELETAL

- Neck Pain
- Arm Pain
- Shoulder Pain
- Hand/Wrist Pain
- Mid Back pain
- Low Back Pain
- Upper Leg/Hip Pain
- Lower Leg/Hip Pain
- Ankle/Foot Pain
- Walking Problems
- Joint Pain/Stiffness/Swelling
- Arthritis
- Jaw Pain/TMJ
- Scoliosis

NERVOUS SYSTEM

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling limbs
- High stress

GENERAL

- Fatigue
- Allergies

- Fever
- Headaches
- Diabetes
- Cancer
- Skin Conditions

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems

- Weight Trouble (Loss/Gain)
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Colitis
- Digestive Problems

GENITO-URINARY

- Bladder/Kidney Trouble
- Painful/Excessive Urination
- Discolored Urine
- C-V-R
- Chest Pain
- Short Breath
- Blood Pressure Problem

- Irregular Heartbeat
- Heart Disease
- Lung Congestion
- Respiratory Condition
- Varicose Veins
- Ankle Swelling
- Stroke

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Earaches
- Hearing Difficulty
- Stuffed Nose

FEMALES ONLY: ARE YOU PREGNANT? Yes /months _____ No When was your last period? _____

- Menstrual Irregularity Menstrual Cramps Vaginal Pain/Infection Breast Pain/Lumps

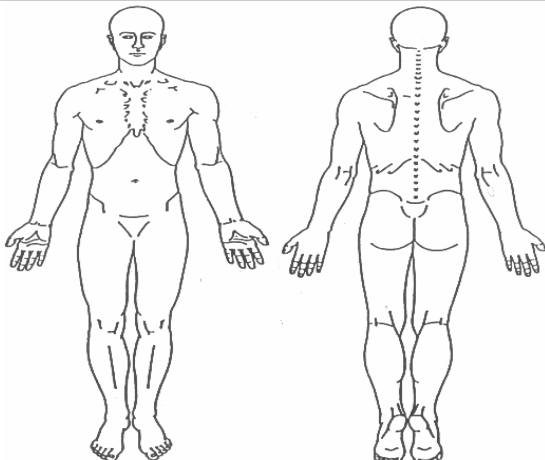
Family Health Profile: At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

- Mother _____ Sister _____ Brother _____
 Father _____ Spouse _____ Child _____

Please fill in diagram below

Using the letters below please mark on these figures the area and type of altered sensation you are experiencing.

- P** = Pain **T** = Tingling **S** = Stiffness
B = Burning **N** = Numbness **M** = Muscle Spasm



Patient signature _____ date _____

DOCTOR'S NOTES:

Recommendations: X-rays Ice/heat EMG MRI

Patient Accepted: YES NO Referred

Doctor's Signature: _____ Date _____

I have reviewed the information contained on this form with the patient