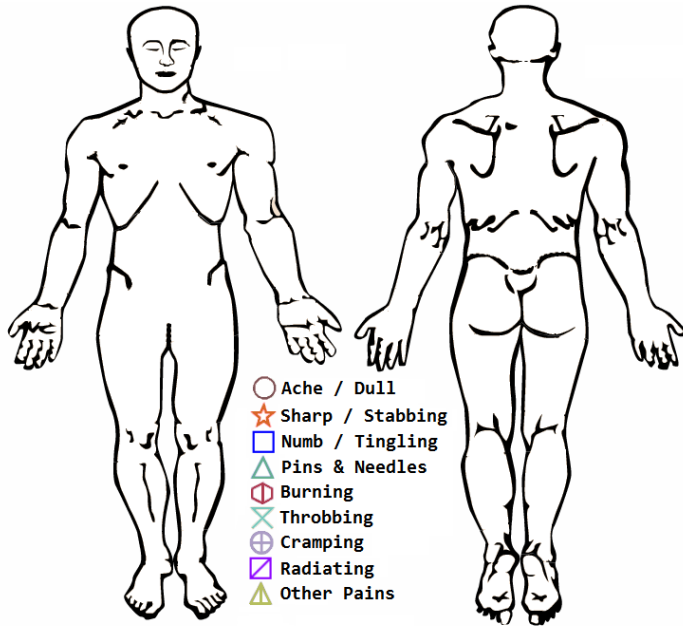




Patient Information:

Date	SSN	Birthday
First Name	Middle Name	Last Name
Sex Male Female	Height	Weight
Married/Civil Union:	Spouse Name	# of Children
Home #	Cell #	Work #
Address		
City	State	Zip
Emergency Contact	Emergency Relation	Emergency Phone
Email		

Patient Symptoms:



○ Ache / Dull
 ★ Sharp / Stabbing
 □ Numb / Tingling
 ▲ Pins & Needles
 ⊕ Burning
 ⊗ Throbbing
 ⊕ Cramping
 ⊞ Radiating
 ▲ Other Pains

Complaint Information:

What is the purpose of your visit?

What is the reason for this visit?

Date of scheduled appointment

When did this condition begin?

How long have you had this condition?

What caused this condition?

Where is the discomfort? Choose all that apply.

Head:	Front of head	Back of head	Right side of head	Left side of head		
Neck:	Front of neck	Back of neck	Right side of neck	Left side of neck		
Back:	Right mid back	Left mid back	Central mid back	Right low back	Left low back	Central low back
Trunk:	Abdomen	Chest	Front of ribs	Back of ribs	Right side of ribs	Left side of ribs
Upper Extremity:	Front of right upper extremity	Rear of right upper extremity	Front of left lower extremity	Rear of left lower extremity		
	Front of right shoulder	Rear of right shoulder	Front of left shoulder	Rear of left shoulder		
	Front of right upper arm	Rear of right upper arm	Front of left upper arm	Rear of left upper arm		
	Front of right elbow	Rear of right elbow	Front of left elbow	Rear of left elbow		
	Front of right wrist	Rear of right wrist	Front of left wrist	Rear of left wrist		
	Front of right hand	Rear of right hand	Front of left hand	Rear of left hand		
Lower Extremity	Front of right lower extremity	Rear of right lower extremity	Front of left lower extremity	Rear of left lower extremity		
	Front of right hip	Rear of right hip	Front of left hip	Rear of left hip		
	Front of right thigh	Rear of right thigh	Front of left thigh	Rear of left thigh		
	Front of right knee	Rear of right knee	Front of left knee	Rear of left knee		
	Front of right leg	Rear of right leg	Front of left leg	Rear of left leg		
	Front of right ankle	Rear of right ankle	Front of left ankle	Rear of left ankle		
	Top of right foot	Bottom of right foot	Right side of right foot	Left side of right foot		
	Top of left foot	Bottom of left foot	Right side of left foot	Left side of left foot		
	OTHER					

Does the discomfort radiate/travel? Yes No

Where does the pain radiate to? Choose all that apply; choose non-radiating if none apply.

Non-radiating

Front of left chest	Front of right chest	Front of left abdomen/groin	Front of right abdomen/groin
Front of left thigh	Front of left lower leg	Radiating to top of left foot	Front of left shoulder
Front of left upper arm	Front of left lower arm	Front of left hand	Front of left face
Front of right thigh	Front of right lower leg	Radiating to top of right foot	Front of right shoulder
Front of right upper arm	Front of right lower arm	Front of right hand	Front of right face
Back of left thigh	Back of left lower leg	Bottom of left foot	Back of left shoulder
Back of left upper arm	Back of left lower arm	Back of left hand	Back of left side of head
Back of right thigh	Back of right lower leg	Bottom of right foot	Back of right shoulder
Back of right upper arm	Back of right lower arm	Back of right hand	Back of right side of head

Describe the quality of the discomfort. Choose all that apply.

Aching	Annoying	Burning	Deep	Diffuse	Dull
Heavy	Intolerable	Pulling	Sharp	Shock-like	Shooting
Stabbing	Stiffness	Throbbing	Tightness	Tingling	OTHER

Complaint #1 Information (2):

Onset of discomfort:	Gradual	Insidious	Recent	Spontaneous	Sudden	Traumatic	Unknown			
Intensity of discomfort:	Mild	Mild to moderate	Moderate	Moderate to severe	Severe					
Severity of discomfort:	1	2	3	4	5	6	7	8	9	10
Frequency of discomfort:	Constant	Frequent	Intermittent	On and off	Random	Recurring				
How has severity of the complaint changed since the onset?	Improved		Stayed the same			Worsened				
What activity is most significantly affected by this discomfort?										
What improves this condition? Choose all that apply.										
Chiropractic adjustment	Cold packs	Exercise	Heat packs	Massage						
Nothing	OTC medications	Physical therapy	Prescription medication	Re-direct attention						
Rest	Stretching	Work	OTHER							
What treatment have you received for this condition up to now?										
None	Acupuncture	Chiropractic care	Craniosacral therapy	Homeopathic medicine						
Hypnosis	Injection therapy	Medical care	Naturopathic medicine	Nutritional supplements						
Occupational therapy	Osteopathic medicine	OTC medications	Physical therapy	Prescribed medications						
Psychotherapy	Reiki	Surgery	OTHER							
Were any diagnostic tests performed to assess this condition (including X-rays, MRIs, etc.)? Yes No Unsure										
Have you ever had any previous episodes of this condition? Yes No										
In what ways does this condition affect your life and your ability to function? Choose all that apply.										
Bending over	Caring for family	Climbing stairs	Concentrating	Dressing myself						
Driving a car	Exercising	Getting in/out of car	Getting to sleep	Grocery shopping						
Household chores	Lifting objects	Looking over shoulder	Love life	Lying down						
Reaching overhead	Rising out of chair or bed	Showering or bathing	Sitting	Standing						
Staying asleep	Using a computer	Walking	Yardwork							
Do you have an additional complaint? Yes No										

Review of Systems:

Musculoskeletal - Other than the musculoskeletal complaints you mentioned already, do you have or have you ever had:

No additional musculoskeletal complaints	Osteoporosis	Arthritis
Scoliosis	Joint or muscle pains/stiffness	Cramping
Swelling, redness deformity of joint(s)	Fractures	Implants, plates, pins or screws
Neck pain	Back problems	Hip disorders
Knee injuries	Foot/ankle pain	Shoulder problems
Elbow/wrist pain	Poor posture	Gout

Neurological - Other than the neurological complaints you mentioned already, do you have or have you ever had:

No additional neurological complaints	Anxiety and/or panic	Depression
Memory issues	Sleeping issues	Headache
Dizziness	Weak muscles	Pins and needles
Numbness	Loss of smell or taste	Temporary loss of vision, smell or hearing
Difficulty concentrating	Stroke	Epilepsy or seizures

Head, Eyes, Ears, Nose and Throat - Do you have or have you ever had:

No complaints	Headaches or migraines	Eye or vision problems	Eyeglasses or contact lenses
Eye surgery	Cataracts	Glaucoma	Nose congestion or sinus trouble
Ear or hearing problems	Dental problems	Gum problems	TMJ problems
Sore throat	Postnasal drip	Swollen lymph nodes	OTHER

Cardiovascular - Do you have or have you ever had:

No cardiovascular complaints	Chest pain or tightness	Palpitations	Swollen legs or feet
High blood pressure	Low blood pressure	High cholesterol or triglycerides	Heart attack
Heart murmur	Congenital heart defects	Rheumatic fever	Leg pain upon walking
Blood clots	Varicose veins	Dizziness	Excessive bruising
Coronary artery disease	OTHER		

Respiratory - Do you have or have you ever had:

No respiratory complaints	Persistent cough	Wheezing	Shortness of breath
Snoring issues	Tuberculosis	Pneumonia	Blood in sputum
Asthma	Apnea	Emphysema	Hay fever
OTHER			

Gastrointestinal - Do you have or have you ever had:

No gastrointestinal complaints	Abdominal pain	Nausea or vomiting	Bloating
Heartburn	Ulcer	Difficulty swallowing	Jaundice
Liver disease	Gallbladder problems	Pancreatitis	Change in bowel habits
Black or bloody stool	Colon cancer or colon polyps	Hemorrhoids	Food sensitivities
Constipation	Severe diarrhea	Irritable Bowel Syndrome	Crohn's disease
Gastric reflux	Collitis	OTHER	

Genitourinary - Do you have or have you ever had:

No genitourinary complaints	Painful or frequent urination	Blood in urine	Kidney stones
Urinary infections	Sexual dysfunction	Incontinence	OTHER

Review of Systems (2):

Endocrine - Do you have or have you ever had:

No endocrine complaints	Feeling hot or cold all the time	Thyroid problems	Diabetes
Increase urination	Excessive thirst	Hyperthyroidism	Hyperparathyroidism
Testosterone deficiency	Cushing's syndrome	Steroid treatments	OTHER

Dermatological and Bleeding - Do you have or have you ever had:

No skin or bleeding complaints	Skin trouble or rashes	Flushing	Change in hair or nails
Excessive acne	Eczema	Psoriasis	Skin cancer
Skin pigmentation issues	Blood in stool	Easy bruising	Gum bleeding
OTHER			

Past, Family and Social History:

List your (or the patient's) past surgical history. Choose all that apply and indicate the year in which the surgeries were performed.

Yes, surgical history		Gastric bypass	Year
No surgical history		Hysterectomy - complete	Year
Abdominal aortic aneurysm repair	Year	Hysterectomy - partial	Year
Appendectomy	Year	Knee - left	Year
Biopsy	Year	Knee - right	Year
Bunionectomy	Year	Lasik	Year
Cardiac bypass	Year	Mastectomy	Year
Cardiac valve replacement	Year	Shoulder - left	Year
Carpal tunnel - left	Year	Shoulder - right	Year
Carpal tunnel - right	Year	Thyroidectomy	Year
Cataract - left	Year	Tonsils	Year
Cataract - right	Year	Tonsils & adenoids	Year
C-section	Year	Wisdom teeth	Year
Cosmetic - face lift	Year	Discectomy level	Year
Cosmetic - nose	Year	Implants	Year
Cosmetic - breast reduction or enlargement	Year	Ganglion cyst	Year
Cosmetic - tummy tuck	Year	Spinal fusion	Year
Cosmetic - other	Year	Transplant	Year
Ear tubes	Year	OTHER	Year
Gall bladder removed	Year		

Describe any past illnesses or conditions the doctor should be aware of and the age at which the illness(es) reportedly occurred.

Yes, past illnesses	No past illnesses (including diabetes, cancer, hypertension and progressive neurological diseases)	
Number of children	Number of pregnancies	Number of deliveries
AIDS/HIV	Age	
Alcoholism	Age	
Alzheimer's	Age	
Anemia	Age	
Anorexia	Age	
Arthritis	Age	
Asthma	Age	
Bleeding disorders	Age	
Breast lump	Age	
Bronchitis	Age	
Bulimia	Age	
Cancer	Age	Explain
Chemical dependency	Age	
Congenital anomaly	Age	Explain
Depression	Age	
Diabetes	Age	
Emphysema	Age	

Past, Family and Social History (2):

Epilepsy	Age	
Extremity issues	Age	Explain
Fracture	Age	Explain
Heart disease	Age	
Hepatitis	Age	
Hereditary disorder	Age	Explain
Hernia	Age	
Herniated disc	Age	
High blood pressure	Age	
High cholesterol	Age	
Hospitalization	Age	Explain
Kidney disease	Age	
Liver disease	Age	
Migraine headaches	Age	
Miscarriage	Age	
Multiple sclerosis	Age	
Natural labor	Age	
Neuromuscular issues	Age	Explain
Osteoarthritis	Age	
Osteoporosis	Age	
Pacemaker	Age	
Parkinson's disease	Age	
Pinched nerve	Age	
Pneumonia	Age	
Polio	Age	
Previous chiropractic care	Age	
Prostate problems	Age	
Psychiatric care	Age	
Rheumatoid arthritis	Age	
Stroke	Age	
Suicide attempt	Age	
Thyroid problems	Age	
Trauma/injury	Age	Explain
Tumor	Age	
Ulcers	Age	
Vaginal infection	Age	
Venereal disease	Age	
OTHER	Age	

Past, Family and Social History (3):

List any past history of accidents or trauma. Choose all that apply.

No previous trauma reported	No new trauma reported since initial intake	Single automobile accident
Multiple automobile accidents	Slip and fall	Multiple slip and falls
Single motorcycle accident	Multiple motorcycles accident	Single boating accident
Multiple boating accidents	Resulting in fracture(s)	Resulting in permanent injury or disability
Resulting in hospitalization(s)	Resulting in no significant injury or loss	Resulting in sprains/strains
Resulting in loss of consciousness	Suicide (including attempts)	OTHER

Are you presently taking any medication? Yes No

Which of the following medications are you presently taking? Choose all that apply.

Over-the-counter	Prescription	Antidepressant	Muscle relaxer
Anti-inflammatory (NSAID)	Steroidal Anti-inflammatory	Antacid	Anti-viral
Aspirin	Chemotherapy	Codeine	Hallucinogenic
Marijuana	Mood elevator	Sleeping pill	Stimulant
Tranquilizer	OTHER		

List your (or the patient's) family health history. Choose all that apply to blood relatives only.

No family history of diabetes, cancer, hypertension and progressive neurological disorders.

Not applicable, patient was adopted	No change in family health history	Unknown		
AIDS/HIV	Alcoholism	Alzheimer's	Anemia	Anorexia
Arthritis	Asthma	Bleeding disorders	Breast lump	Bronchitis
Bulimia	Cancer	Chemical dependency	Congenital anomaly	Depression
Diabetes	Emphysema	Epilepsy	Extremity issues	Fracture
Heart disease	Hepatitis	Hereditary disorder	Hernia	Herniated disc
High blood pressure	High cholesterol	Hospitalization	Kidney disease	Liver disease
Migraine headaches	Miscarriage	Multiple sclerosis	Natural labor	Neuromuscular issues
Osteoarthritis	Trauma/injury	OTHER		

What are your (or are the patient's) current work habits? Choose all that apply.

No change in work habits since condition began	Cannot not work due to presenting condition	None reported				
Permanently fully disabled	Permanently partially disabled					
0 to 20 hours per week	20 to 40 hours per week	40 to 50 hours per week				
50 to 60 hours per week	60 to 70 hours per week	Over 70 hours per week				
Full-time	Part-time	Homemaker	Retired	Student	Unemployed	
Mostly sitting	Mostly standing	Mostly walking	Light labor	Moderate labor	Heavy labor	Sedentary
Computer	Repetitive	Telephone	Difficult	Enjoyable	Relaxed	Stressful

Past, Family and Social History (4):

How would you describe your (or the patient's) personal social habits? Choose all that apply.

No change in social habits since injury	Does not smoke, drink alcohol or take recreational drugs	
A social drinker	A light drinker	A moderate drinker
A heavy drinker	An alcoholic	A recovering alcoholic
Current every day smoker	Current some day smoker	Ex-smoker
Heavy tobacco smoker	Light tobacco smoker	Never smoked tobacco
Smoker, current status unknown	Unknown if ever smoked	
Does not drink caffeine	Drinks 1 cup of caffeine in the morning	Drinks 2 to 4 cups of caffeine per day
Drinks 5 or more cups of caffeine per day		
Does not use recreational drugs	Light use of recreational drugs	Moderate use of recreational drugs
Heavy use of recreational drugs	Is drug addicted	Is a recovering drug addict

How would you describe your (or the patient's) present exercise habits? Choose all that apply.

No changes in exercise habits since condition began

Daily	None	Every other day	Few times a week	Once a week	Almost nothing
Aerobic	Stretching	Strength	Baseball	Basketball	Blading
Boating	Climbing	Cycling	Football	Golf	Handball
Hang gliding	Hiking	Ice skating	Mountain climbing	Ping-Pong	Racquetball
Running	Skiing	Skydiving	Snowboarding	Soccer	Surfing
Tennis	Volleyball	Walking	Waterskiing	Weight training	
Weight training with a personal trainer	Pilates	Spinning	Step	Yoga	
Zumba					

How would you describe your (or the patient's) diet and nutritional status? Choose all that apply.

No changes in diet or nutrition since condition began

Controlled	Out-of-control	Restricted	Unrestricted	1 to 2 meals a day
2 to 3 meals a day	More than 3 meals a day	Reports eating too little	Reports eating too much	Binges
Purges	Balanced	High protein	Low carbohydrate	Low-fat
Low-cholesterol	No red meat	Atkins	Diabetic	Gluten free
Ideal Protein	Jenny Craig	Kosher	Macrobiotic	Paleo
Raw food	South Beach	Vegan	Vegetarian	Weight Watchers
Zone	Does not take daily supplements		Takes daily supplements	OTHER

For Men Only:

Do you have pain or lump in scrotum or testicles?	Yes	No	Unsure	Do you have discharge from your penis?	Yes	No	Unsure
Do you have impaired libido (sex drive)?	Yes	No	Unsure	Do you have prostate problems?	Yes	No	Unsure
When was your last prostate exam?	Approximate Date:			Never had one			
When was your last PSA (Prostate-Specific Antigen) test?	Approximate Date:			Never had one			
What was your PSA (Prostate-Specific Antigen) level on your latest test?							

Patient Social

Alcohol:	Daily	Weekly	Occasionally	Never	Caffeine:	Daily	Weekly	Occasionally	Never
Diet Food Products:	Daily	Weekly	Occasionally	Never	Drugs:	Daily	Weekly	Occasionally	Never
OTC Stimulants:	Daily	Weekly	Occasionally	Never	Exercise:	Daily	Weekly	Occasionally	Never
Homemade Food:	Daily	Weekly	Occasionally	Never	Processed:	Daily	Weekly	Occasionally	Never
Soft Drinks:	Daily	Weekly	Occasionally	Never	Tobacco:	Daily	Weekly	Occasionally	Never
Water:	Daily	Weekly	Occasionally	Never					

Chiropractic Experience:

Who referred you to our office:

Where did you hear about us? Newspaper Sign Yellow Pages Mailing Community Event Other

Have you been adjusted by a chiropractor before? Yes No If yes, Why?

Doctor's Name: Approximate Date of Visit

Has any member of your family ever seen a wellness chiropractor? Yes No

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

I want the Doctor to select the type of care appropriate for my condition

Relief care: Symptomatic relief of pain or discomfort.

Corrective care: Correcting and relieving the cause of the problem as well as the symptom

Comprehensive care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care

Personal Health History

Last Physical Exam: Primary Phys: Phys Phone #:

Phys City: Phys State: Phys Zip:

Health Conditions:

Previous Chiro Care: Yes No Date: Condition(s) treated:

Chance Pregnant: Yes No Planning: Yes No

Medications:

Supplements:

Were you aware that...

Chiropractic is the largest natural healing profession in the world? Yes No Doctor's of Chiropractic work with the nervous system? Yes No

The nervous system controls all bodily functions and systems? Yes No

Signature

Date: