



Name: _____ Todays Date: _____

Phone Number: _____ Age: _____ Date of Birth: _____ Gender: _____

Address: _____ City, State: _____ Zip Code: _____

Email Address: _____ Primary Doctor: _____

Emergency Contact Name and Phone Number: _____

Occupation: _____ Work Activity: Sitting _____ Standing _____ Manual Labor _____

How did you hear about our office? Referral: _____ Doctor _____ Website _____ Other _____

PRESENT CONDITION

Are you here because of: Work Injury? Yes _____ No _____ Auto Accident? Yes _____ No _____

What is the reason you are seeing us today? _____

Where are you feeling the problem? _____

When did this start? _____ How did it start? _____

Have you had this similar condition before? Y: _____ N: _____

How bad is your pain/ache? Please circle (0=no pain 10=most pain) 0 1 2 3 4 5 6 7 8 9 10

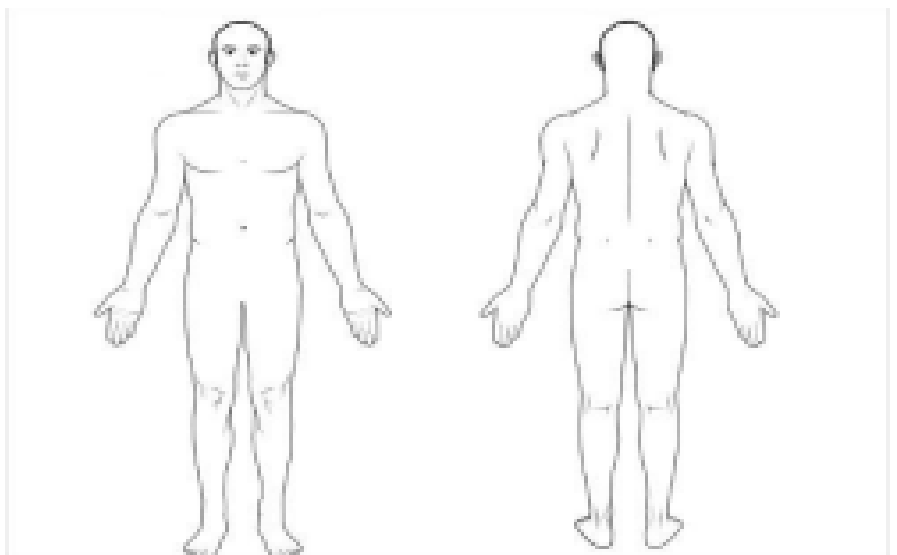
How frequent is your problem? Constant _____ Frequent _____ Occasional _____ Comes & Goes _____

What activities aggravate your condition? _____

Do you feel your condition is getting:
Worse _____ Better _____ No change _____

Please indicate on the body diagram, using the appropriate symbols, where you are having symptoms.

- P-Pain
- N-Numbness
- W-Weakness
- S-Shooting
- A-Aching



Have you ever been to a chiropractor before?: No_____ Yes (name):_____

List previous treatments for this condition:_____

Do you smoke?: Yes_____ No_____ Do you exercise?: Yes (activities)_____ No_____

Rate your sleep, hours per night: <4 4-6 6-8 8-10 12+ Rate your diet: Poor Fair Medium Good Excellent

Please list all medications you are currently taking:_____

Please list any surgeries/operations:_____

Please list any familial medical conditions: (ex Diabetes, Stroke, High Blood Pressure, Cancer, Heart Disease)

PLEASE REVIEW AND INDICATE IF YOU HAVE EXPERIENCED THE FOLLOWING SYMPTOMS IN THE PAST 3 MONTHS

P = PREVIOUS O = OCCASIONAL F = FREQUENT

GENERAL:

- _____ dizziness
- _____ fainting
- _____ headaches
- _____ loss of sleep
- _____ depression
- _____ numbness
- _____ loss of weight

PAIN/NUMBNESS:

- _____ arms
- _____ hands
- _____ hips
- _____ legs
- _____ knees
- _____ ankles
- _____ feet
- _____ tailbone
- _____ sciatica
- _____ shoulders

RESPIRATORY:

- _____ chest pain
- _____ chronic cough
- _____ difficulty breathing

CARDIOVASCULAR:

- _____ rapid heartbeat
- _____ swelling of ankles
- _____ hardening of arteries
- _____ high blood pressure
- _____ low blood pressure

EARS, NOSE, & THROAT:

- _____ ear aches
- _____ ear ringing
- _____ sinus infections
- _____ hoarseness

SKIN:

- _____ bruise easily
- _____ hives or allergies

GASTROINTESTINAL:

- _____ constipation
- _____ diarrhea
- _____ difficult digestion
- _____ stomach pain
- _____ nausea
- _____ vomiting

GENITOURINARY:

- _____ blood in urine
- _____ urine leakage
- _____ painful urination

WOMEN ONLY:

- _____ cramps
- _____ irregular cycle
- _____ painful cycle

Pregnant: Y or N

EDD: _____