

Acct # _____

Date: _____

Name: _____ Birth Date: ____-____-____ Age: ____ Male Female

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

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email Address: _____ Occupation: _____

Employer: _____ Social Security: _____

Marital Status: M S D W Spouse's Name: _____ Spouse's Occupation: _____

Name and Ages of Children: _____

Emergency Contact : _____ Phone: _____ Relationship: _____

Health Insurance: Yes ____ No ____

Whom may we thank for referring you to this office? _____

PAST HISTORY

Have you suffered with this or a similar problem in the past? No Yes

If yes, how many times? _____ When was the last episode? _____ Other forms tried: No Yes

If yes, please state what type of treatment and who provided it: _____

How long ago? _____ What were the results: Favorable Unfavorable ->

Please explain: _____

Have you seen a chiropractor before for this condition? No Yes

What were the results? _____

Is your problem the result of **ANY** type of accident? Yes No

If yes, identify type: Auto Work Home Other (*please explain*) _____

Date of Accident: ____-____-____ approximate time of day? ____am ____pm

Identify all sports/recreational activities you participate in: _____

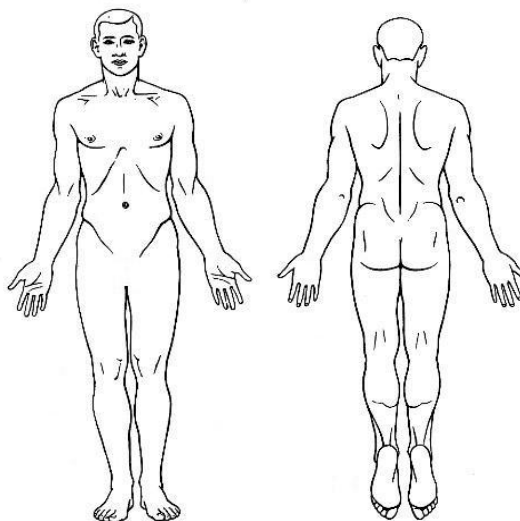
When was your most recent stress or strain during your activity? _____

Was any treatment received? No Yes **If yes**, explain: _____

Identify any other injury (s) to your spine, minor or major, that the doctor should know about:

PLEASE MARK the areas on the Diagram with the following letters to describe all your symptoms:

- R= Radiating**
- B=Burning**
- D=Dull**
- A=Aching**
- N= Numbness**
- S=Sharp/Stabbing**
- T=Tingling**



Review of Systems

Please indicate with a **P** for Past, **C** for Current, or **N** for Never for each symptom.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pregnant (now) | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Jaw Pain, TMJ | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Pain w/ Cough/Sneeze | <input type="checkbox"/> Irritable | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Foot or Knee Problems | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Heartburn/Reflux |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Anxiety | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Skin Problem | <input type="checkbox"/> Lung Problem | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Impotence | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Liver Trouble | |
| <input type="checkbox"/> Hepatitis (A,B,C) | <input type="checkbox"/> Menopausal Problems | <input type="checkbox"/> Gall Bladder Trouble | |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | | <input type="checkbox"/> Numb/Tingling legs, feet, toes | |

Past History

Please identify ALL PAST and CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	-> _____		
SURGERIES	-> _____		
CHILDHOOD DISEASES	-> _____		
ADULT DISEASES	-> _____		

FAMILY HISTORY

Does anyone in your family suffer with the same condition (s)? No Yes

If yes, whom: grandmother grandfather mother father sister brother son daughter

Have they ever been treated for their condition? No Yes I don't know

Any other hereditary conditions the doctor should be aware of: No Yes: _____

SOCIAL HISTORY

Smoking Cigars Pipe Cigarettes -> How often? Daily Weekends Occasionally Never

Alcoholic Beverage: consumption occurs -> Daily Weekends Occasionally Never

Recreational Drug use: consumption occurs -> Daily Weekends Occasionally Never

List Prescription and Non-Prescription drugs that you take:

List Vitamins and Supplements that you take:

The Review of Systems, Past History, Family History, and Social History was reviewed with the patient.

By _____ Date _____

Name: _____

Date: _____

Complaint #1: _____

Onset	Location	Pain Radiating Into	Type of Pain	Severity	Time out of Day	What Makes It Worse?
____ / ____ / ____	Left	Left Head	Aching	1 (No Pain)	Constant	Everything
Today	Right	Right Shoulder	Burning	2	Frequent	Nothing
This Week	Both	Front Arm	Deep	3	Intermittent	Lifting
This Month	Front	Back Hand	Dull	4	Occasional	Working
This Year	Back	Ribs	Numbing	5	Infrequent	Sitting
Chronic		Buttocks	Sharp	6		Bending
		Hip	Soreness	7		Standing
CAUSE:		Leg	Stabbing	8		Sneezing
_____		Foot	Tenderness	9		Coughing
_____		Other _____	Tingling	10 (Worst)		

Dr. Notes: _____

____Prevent? _____Benefit? _____Why now? _____

Complaint #2: _____

Onset	Location	Pain Radiating Into	Type of Pain	Severity	Time out of Day	What Makes It Worse?
____ / ____ / ____	Left	Left Head	Aching	1 (No Pain)	Constant	Everything
Today	Right	Right Shoulder	Burning	2	Frequent	Nothing
This Week	Both	Front Arm	Deep	3	Intermittent	Lifting
This Month	Front	Back Hand	Dull	4	Occasional	Working
This Year	Back	Ribs	Numbing	5	Infrequent	Sitting
Chronic		Buttocks	Sharp	6		Bending
		Hip	Soreness	7		Standing
CAUSE:		Leg	Stabbing	8		Sneezing
_____		Foot	Tenderness	9		Coughing
_____		Other _____	Tingling	10 (Worst)		

Dr. Notes: _____

____Prevent? _____Benefit? _____Why now? _____

Complaint #3: _____

Onset	Location	Pain Radiating Into	Type of Pain	Severity	Time out of Day	What Makes It Worse?
____ / ____ / ____	Left	Left Head	Aching	1 (No Pain)	Constant	Everything
Today	Right	Right Shoulder	Burning	2	Frequent	Nothing
This Week	Both	Front Arm	Deep	3	Intermittent	Lifting
This Month	Front	Back Hand	Dull	4	Occasional	Working
This Year	Back	Ribs	Numbing	5	Infrequent	Sitting
Chronic		Buttocks	Sharp	6		Bending
		Hip	Soreness	7		Standing
CAUSE:		Leg	Stabbing	8		Sneezing
_____		Foot	Tenderness	9		Coughing
_____		Other _____	Tingling	10 (Worst)		

Dr. Notes: _____

____Prevent? _____Benefit? _____Why now? _____

Other Complaints: _____

ACTIVITIES OF DAILY LIVING

How is your current condition affecting your ability to carry out activities that are routinely part of your life? Please circle the appropriate number for each activity that indicates your ability to perform the following activities:

	<i>Normal</i>	<i>Minimally affected</i>	<i>Moderately affected</i>	<i>Severely affected</i>	<i>Unable To Do</i>
Bending	0	1	2	3	4
Doing Computer Work	0	1	2	3	4
Gardening	0	1	2	3	4
Leisure, recreational, sports activities	0	1	2	3	4
Up and down stairs	0	1	2	3	4
Sleeping normally	0	1	2	3	4
Watching TV	0	1	2	3	4
Carrying	0	1	2	3	4
Dancing	0	1	2	3	4
Lifting	0	1	2	3	4
Grooming - bath, comb hair, shave...	0	1	2	3	4
Dressing - manage normal dressing activities	0	1	2	3	4
Pushing	0	1	2	3	4
Rolling Over	0	1	2	3	4
Sitting	0	1	2	3	4
Working	0	1	2	3	4
Climbing	0	1	2	3	4
Driving	0	1	2	3	4
Sexual Activities	0	1	2	3	4
Running, Jogging	0	1	2	3	4
Walking	0	1	2	3	4
Vacuuming	0	1	2	3	4
Food prep, cooking, eating	0	1	2	3	4
Reaching above head and across body	0	1	2	3	4
Job requirements - perform all duties	0	1	2	3	4