

Name _____ Address _____

City _____ State _____ Zip _____ Home Phn _____

Cell Phn _____ Pager _____ E-mail Home _____

SSN _____ Date of Birth _____ Age _____ Height _____ Weight _____

Male Female Single Married Divorced # Of Children _____ Spouse Name _____

How were you referred to our office? _____

Employer _____ Address _____

City _____ State _____ Zip _____ Wk Phn _____ Occupation _____

Have you ever had Chiropractic care before? _____ If yes, when? _____

If you are experiencing any health problems, please list your chief complaints in order of severity

1 _____ For how long? _____

2 _____ For how long? _____

3 _____ For how long? _____

List other doctors consulted for these conditions: _____

Name of family physician _____

Do you ever experience any of these complaints while working? _____ If yes, describe what activities at work that may be causing you to experience these complaints: _____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? _____ If yes, please explain: _____

If this is due to an injury or accident, what is the date of the injury? _____

Has this problem been getting better, worse, or staying the same? _____

What activities make your conditions worse? _____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

Please list any injuries or illnesses that you have had that are not listed above: _____

Please indicate medications (over the counter) / prescriptions you are currently taking: Aspirin/Tylenol

Pain Killers Muscle relaxers Insulin Tranquilizers Birth Control Pills Others _____

Have you been involved in an auto accident in the last 12 months? _____ If yes, when? _____

Health insurance _____ Policy Holder _____

Claims address _____ Policy Holder _____

Spouse's health insurance _____ Policy Holder _____

Claim's address _____ Policy Holder _____

IMPORTANT: Please check (X) all present symptoms.

HEAD:

- Headache
 - sinus (allergy)
 - entire head
 - back of head
 - forehead
 - temples
 - migraine
- Head feels heavy
- Loss of memory
- Light-Headedness
- Fainting
- Light bother eyes
- Blurred vision
- Double vision
- Loss of vision
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Buzzing in ears

NECK:

- Pain in neck
- Neck pain with movement
 - forward
 - backward
 - turn to left
 - turn to right
 - bend to left
 - bend to right
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

ARMS AND HANDS:

- Pain in upper arm
- Pain in elbow
- Movement aggravated
- Tennis elbow
- Pain in forearm
- Pain in hands
- Pain in fingers
- Sensation of pins and needles in arms
- Sensation of pins and needles in fingers
- Numbness in arms (R-L)
- Fingers go to sleep
- Hands cold
- Swollen joints in fingers
- Sore joints in fingers
- Arthritis in fingers
- Loss of grip strength

SHOULDERS:

- Pain in shoulder joint (R-L)
- Pain across shoulders
- Bursitis (R-L)
- Arthritis (R-L)
- Can't raise arm
 - above shoulder level
 - over head
- Tension in shoulders
- Pinched nerve in shoulder (R-L)
- Muscle spasms in shoulders

MID BACK:

- Mid-back pain
- Location _____
- Pain between shoulder blades
- Sharp stabbing
- Dull ache
- Pain from front to back
- Muscle spasms
- Pain in kidney area

CHEST:

- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Dimpled or orange peel breast
- Irregular heartbeat

ABDOMEN:

- Nervous stomach
- Foods can't eat _____
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK:

- Low back pain
- Upper lumbar
- Lower lumbar
- Sacroiliac
- Low back pain in worse when:
 - working
 - lifting
 - stooping
 - standing sitting
 - bending
 - coughing
 - lying down (sleeping)
 - walking
- Pain relieved with: _____
- Slipped disk
- Low back feels out of place
- Muscle spasms
- Arthritis

HIP, LEGS, AND FEET:

- Pain in buttocks
- Pain in hip joint
- Pain down leg
- Pain down both legs
- Knee pain
 - inside
 - outside
- Leg cramps
- Crams in feet
- Pins and needles in legs
- Numbness of leg
- Numbness of toes
- Feet feel cold
- Swollen ankles
- Swollen feet

WOMEN ONLY:

- Cramping
- Hysterectomy
- Menopause
- Tumors
- Are you or do you think you are pregnant?

MEN ONLY:

- Urinary frequency _____
- Difficulty in starting
- Night urination
- Prostrate pain/swelling

GENERAL:

- Nervousness
- Irritable
- Depressed
- Fatigue
- Generally feel run-down
- Normal sleep hrs/night _____
- Loss of sleep hrs/night _____
- Loss of weight lbs _____
- Gain weight lbs _____
- Coffee cups/day _____
- Tea cups/day _____
- Cigarettes pack/day _____
- Other _____
- Diabetes
- Hypoglycemia

REMARKS:

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.



Relief Care

Relief care is that care necessary to get rid of your symptoms of pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not from fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms of pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care

Corrective Care

Check here if you want the Doctor to select the type of care appropriate for your condition

Date

Patient's Signature

If this is related to an Auto Accident or Work Injury, please fill out the corresponding form.
Thank You!