

REASON FOR VISIT

(Print Name) _____

(Today's Date) _____

Please Describe Your Pain and/or Condition? _____

(Please Indicate the area of your pain)

(Please Indicate your level of pain)

Use These Symbols
To Indicate Any
Sensations You Are
Currently
Experiencing

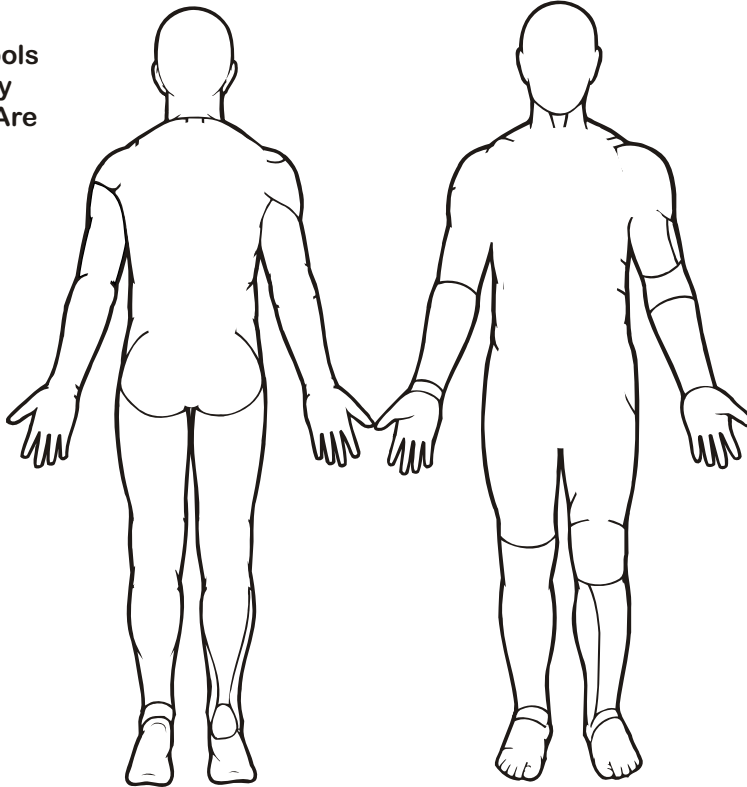
Aching
AAA

Burning
XXX

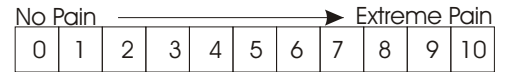
Numbness
000

Tingling
+++

Stabbing
/////



How Bad Is Your Neck Pain?



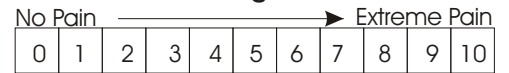
How Bad Is Your Back Pain?



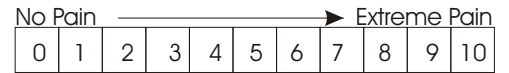
How Bad Is Your Arm Pain?



How Bad Is Your Leg Pain?



Other Pain? _____



When did your symptoms appear? _____

Have you had this condition in the past? Yes No If, yes explain _____

Is this condition getting progressively worse? Yes No

Is this condition? Constant Or Does it come & go

Does this condition interfere with your Work Sleep Daily Routine Recreation Exercise

Activities that are painful to perform Sitting Standing Walking Bending Lying Down

Other Doctor seen for this condition: Name: _____ M.D. Chiropractor D.O.

What type of treatment have you already received for this condition? Medication _____

Surgery Physical Therapy Chiropractic Care None Other _____

Check the type(s) of care desired:

Relief Care (care that is based on relief of current condition)

Maintenance Care (care that is based on regular chiropractic adjustments)

Would like to discuss this matter further

HEALTH HISTORY

(Print Name) _____

(Today's Date) _____

Have you been to a Chiropractor in the past? Yes No _____

Date of last: Spinal Exam _____
 Spinal X-ray _____
 Adjustment _____

List any these conditions you have experienced in the past year?:

- Neck Pain Mid-Back Pain Lower Back Problems
- Headaches Pain in the arms/hands Pain in the legs/feet
- Sinus Problems

Have you ever had any of the following diseases/medical condition(s)?

- Heart Attack / Stroke Diabetes / Tuberculosis Kidney Problems Anemia
- Congenital Heart Defect Heart Surg./Pacemaker Difficulty Breathing Rheumatic Fever
- Alcohol / Drug Abuse Mitral Valve Prolapse Artificial Bones/Joints Ulcers / Colitis
- HIV+ / Aids Venereal Disease Heart Murmur Asthma
- High/Low Blood Pressure Shingles Artificial Valves Chemotherapy
- Emphysema/Glaucoma Hepatitis Arthritis
- Fainting/Seizures/Epilepsy Psychiatric Problems Cancer

Other _____

List any other serious condition(s) not mentioned above: _____

Medications	Allergies	Vitamins/Herbs/Minerals

List any surgeries you have had.	Date

<p>Exercise</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy 	<p>Work Activity</p> <ul style="list-style-type: none"> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor 	<p>Habits</p> <ul style="list-style-type: none"> <input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee/Caffeine Drinks <input type="checkbox"/> Appetite
		<p>Packs / Day _____</p> <p>Drinks / Week _____</p> <p>Cups / Day _____</p> <p><input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good</p>

For Women: Are you pregnant? Yes No Not sure If yes, how far along? _____