

Last Name _____ First _____ Middle _____
 Address _____ SS# _____ Birthdate ____/____/____ Age ____
 City _____ State _____ Zip _____ DL# _____
 Occupation _____ Employer _____ Spouse Occupation _____
 Full Time Part Time Retired Not Employed Employer _____
 # Children _____ Phone _____ Work _____ Cell _____ eMail _____
 Contact in case of emergency _____ Referred By _____

MY GOAL FOR CONSULTING WITH THE DOCTOR: Temporary relief Lasting correction Let doctor recommend the best type of care for you.

Major Complaint _____ Timing: 0-25% 26-50% 51-75% 76-100% of the time

How serious do you think your problem is? _____
 On a scale of 0-10, how committed are you to getting rid of this problem? (0= not committed 10= totally committed) _____

What caused it? How did it start? (Gradual/Injury) _____

Have you had this or similar condition in the past? _____

Constant Comes and goes _____ Is it progressively getting worse? Yes No

Medications you are on now _____

What makes it better? _____ Worse? _____

Describe the problem when it is at its worst _____

How has this problem affected your life? _____

1. Difficulty in performing basic activities of daily living - bathing/showering shaving dressing other _____

2. Daily duties: difficulty in performing cleaning washing dishes sweeping mopping other _____

3. Hobbies: slowing or prevention of certain hobbies _____

4. Work: I just get through slower production due to pain cannot work at all

5. How does this problem affect your family/social life? _____

What activity would you like to be able to do again that is difficult or that you cannot do now? _____

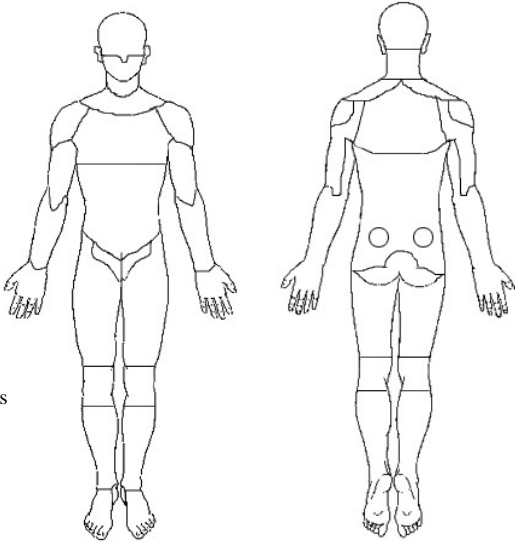
Is this a new/old illness? Treatment? _____ Doctor _____

Mark any areas of pain on diagram.

Please indicate with a (C) **CONDITIONS YOU HAVE NOW** or with a (P) conditions you have had **IN THE PAST**. If neither applies, mark (NA). Don't leave any blanks.

Radiation
 Arms
 Hands
 Legs
 Feet

A=ache
 B=burn
 N=numbness
 T=tight
 S=sharp
 D=dull
 P=pins & needles
 O=other



- | | | |
|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Weak muscles | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Neck problem | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Shoulder problem | <input type="checkbox"/> Memory problem | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Arm problem | <input type="checkbox"/> Mental/emotion | <input type="checkbox"/> Heart problem (Angina, MI,CAD,COPD,CHF) |
| <input type="checkbox"/> Numb arms/fingers | <input type="checkbox"/> Extreme worry | <input type="checkbox"/> Blood Pressure High/Low |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney problem |
| <input type="checkbox"/> Low back problem | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Indigestion or nausea |
| <input type="checkbox"/> Leg problem | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Numb legs/toes | <input type="checkbox"/> Vision problem | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Loss of feeling | <input type="checkbox"/> Ear infection | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Stiff joints | <input type="checkbox"/> Walking problem | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Painful joints | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sore muscles | <input type="checkbox"/> Freq colds | <input type="checkbox"/> Menstrual cramps |
| <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Fatigue | |
| <input type="checkbox"/> Broken bones | | |

Rate the severity 0-10 _____ (0= no pain, 10=excruciating pain)

- Have you ever had surgery or been hospitalized? _____
- When did you last see a chiropractor _____
 Doctor Name _____
- Last time you had spinal x-rays _____
- Family History:** List any conditions affecting your family: _____
- Female: Are you pregnant at this time? Yes No Due Date _____

ADL Restricts daily activities Restricts regular exercise Difficulty walking/standing/sitting Household duties Other _____

TRAUMA FROM BIRTH TO PRESENT. List by date/describe.
 1. Injuries or falls _____
 2. Car/bike accidents _____
 3. Other _____

Sign & date: