

## Introduction and History

Date: \_\_\_\_\_

Name:	Date of birth (Month/Day/Year):
Home Address and Phone Number:	Employer and Work Phone Number:
E-Mail:	Occupation:
Cell Phone:	Social Security Number
Family Medical Doctor:	Referred by (please include person's name): <input type="checkbox"/> Friend/Family <input type="checkbox"/> M.D. / D.C. <input type="checkbox"/> Internet/Add
Have you had Chiropractic care before? If so, when and by whom?	Children's Name and Ages:
Spouse's Name and Occupation:	Hobbies:
Please circle sex:    Male    Female	

### Why this form is important:

Our office focuses on your ability to be healthy. Our goals are to **first** address the issues that brought you to this office, and **second**, offer the **opportunity to improve your health potential in the future**. In order to give you the best possible Chiropractic care, we will need to discover any '**stresses**' that are placed on your body. Please take the time to fill out this form completely, as each question gives us a clearer picture of your current health status.

### Reason for consulting this office

**Wellness / Prevention Care** - *I wish to continue my Chiropractic Wellness Care.* Just answer the following questions that apply.

Please describe your current problem, including the effect it has had on your life:

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Please describe the character of your pain (check all that apply)

- Sharp/Stabbing     Sharp/Dull     Achy     Dull     Soreness     Weakness  
 Throbbing/Gnawing     Numbness     Shooting     Gripping/Constricting  
 Burning     Tingling     Other: \_\_\_\_\_

Your name: \_\_\_\_\_

How often are the complaints present?

- Constant (76-100%)  Frequent (51-75%)  Occasional (26-50%)  Intermittent (25% or less)

When is the pain or symptoms worse:

- When you wake up  During the day  After work  In the evening  After eating  
 While sleeping

How bad is your pain or ache? Please circle a number (0= no pain, 10 = unbearable pain)

0 1 2 3 4 5 6 7 8 9 10

Since your problem began is the pain :  increasing  decreasing  not changing

When did your problem begin: \_\_\_\_\_ (specific date if possible)

**Please draw on the diagram where you feel your symptoms: →**

Do you sleep on your:

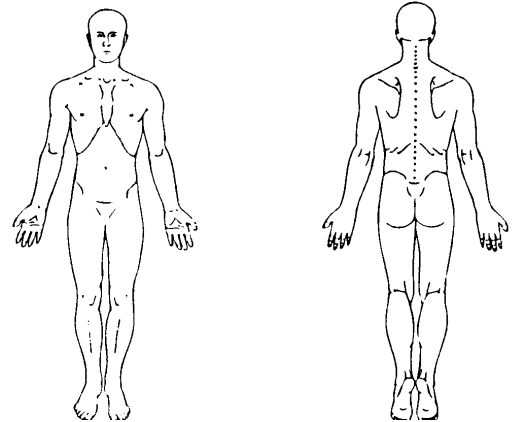
- Back  Stomach  Left Side  Right Side

Physical Activity at work:

- Sitting more than 50%  Light manual labour  
 Heavy manual labour

General physical activity:

- No regular exercise program  
 Light exercise program  
 Strenuous exercise program



How would you rate your stress level:

- No Stress  Minimal Stress  
 Moderate Stress  Greatly Stressed

Do you currently smoke? Yes No. If YES please indicate how many packs a day: \_\_\_\_\_

Number of years: \_\_\_\_\_

Who else have you seen for this condition: \_\_\_\_\_

Please describe any falls, auto accidents or major injuries (include Month/Year, Type of accident):  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any and all past surgery: \_\_\_\_\_

Please list ANY and ALL medication (prescription and over the counter): that you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

**Please Circle Any That Apply: PERSONAL HISTORY:** Aneurysm, Osteoporosis, Diabetes, Thyroid Disease, Arthritis, Cancer, Stroke, Heart Condition, Hypertension, Polio, Asthma, Psoriasis. Other: \_\_\_\_\_

**Please Circle Any That Apply: FAMILY:** Aneurysm, Osteoporosis, Diabetes, Thyroid Disease, Arthritis, Cancer, Stroke, Heart Condition, Hypertension, Polio, Asthma, Psoriasis. Other: \_\_\_\_\_

**Please check all symptoms or areas where you have problems, even if they do not seem related to your current problem.**

- |  |  |                                       |  |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Buzzing/Ringing in Ears     | <input type="checkbox"/> Lungs        | <input type="checkbox"/> Low Back Pain           |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Fatigue                     | <input type="checkbox"/> Heart        | <input type="checkbox"/> Hip Pain                |
| <input type="checkbox"/> Eyes/Vision         | <input type="checkbox"/> Fainting                    | <input type="checkbox"/> Stomach      | <input type="checkbox"/> Leg Pain/Cramps         |
| <input type="checkbox"/> Concentration Loss  | <input type="checkbox"/> Sinus                       | <input type="checkbox"/> Indigestion  | <input type="checkbox"/> Poor Circulation        |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Neck Pain/Stiffness         | <input type="checkbox"/> Bladder      | <input type="checkbox"/> Numb Feeling            |
| <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Shoulder                    | <input type="checkbox"/> Liver        | <input type="checkbox"/> Feeling of Pins/Needles |
| <input type="checkbox"/> Sleeping            | <input type="checkbox"/> Upper Back                  | <input type="checkbox"/> Colon        | <input type="checkbox"/> Hot Flashes             |
| <input type="checkbox"/> Loss Energy         | <input type="checkbox"/> Mid Back                    | <input type="checkbox"/> Kidney       | <input type="checkbox"/> Cold Sweats             |
| <input type="checkbox"/> Tired Mornings      | <input type="checkbox"/> Chest Pain                  | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea                |
| <input type="checkbox"/> Loss of Taste/Smell | <input type="checkbox"/> Menstrual Pain/Irregularity | <input type="checkbox"/> Urination    | <input type="checkbox"/> Fever                   |

- Do you drink bottled or filtered water: Yes No
- Do you belong to a health club or exercises regularly: Yes No

Please list all supplements and vitamins you take: \_\_\_\_\_  
\_\_\_\_\_

**How would you rate your health:**

Yuk I've never felt worse  
1    2    3    4    5    6    7    8    9    10  
Wow I feel great!

How committed are you to improving your health:

Nah, not important  
1    2    3    4    5    6    7    8    9    10  
I want to be 100% healthy!

Do you want to live to be a healthy 85 years old?      Yes    No

What is 'being healthy' to you (check all that apply)?

- |   |  |
|---|--|
| <input type="checkbox"/> Not being sick   | <input type="checkbox"/> Being symptom free                |
| <input type="checkbox"/> Having energy to do what I want, when I want                       | <input type="checkbox"/> Not needing to take time off work |
| <input type="checkbox"/> To fully enjoy all aspects of life to the fullest extent possible. |  |

What is your goal or expectations with Chiropractic care: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Care and Nutritional Care, and I give authority for these procedures to be performed. I have been informed of the Clinic's financial policy and agree that I am responsible for all bills incurred at this office. I have had an opportunity to review the privacy policy and agree to its terms.

Patient/Guardian Name: \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_

Date: \_\_\_\_\_