LAST NAME _____ FIRST NAME _____ MIDDLE _____

ADDRESS _____ SS# _____ BIRTHDATE _____ AGE _____

CITY _____ STATE _____ ZIP _____ DL# _____

OCCUPATION _____ SPOUSE _____

EMPLOYER _____ SPOUSE'S OCCUPATION _____

PHONE _____ WORK _____ CELL _____ # OF CHILDREN _____ 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: (Worst Pain) _____

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

How Serious Do You Think Your Problem Is? _____

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

When was the first time you became aware of this problem? How long have you had it?) _____

☐ 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?

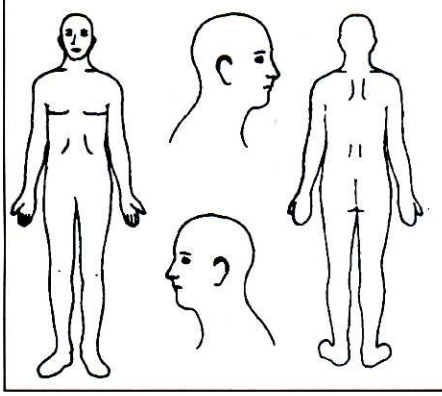
1. Difficulty In Performing Basic Activities of Daily Living - ☐ Bathing/showering ☐ Shaving ☐ Dressing
2. Daily duties: Diffficulty In Performing - ☐ Cleaning ☐ Washing Dishes ☐ Sweeping Mopping
3. Hobbies: Slowing Or Prevention Of Certain Hobbies _____
4. Work: ☐ I Just Get Through = Slower Production Due To Pain ☐ Cannot Work At All
5. Family/Social: ☐ Not As Easy Going ☐ Grumpy Feeling Due To Pain ☐ Depression/Angry Due To Pain

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

_____

This was a new/old illness. Treatment? _____ Doctors _____

Please mark your areas of pain on the figures below.



Mark any other sysmptoms you have had in past 6 months.

Rate the severity of your problem. 1-10 (1 - slight problem, 10- severe) pain. Leave blank if doesn't apply.

Musculoskeletal
- ___ Headaches
- ___ Neck Problems
- ___ Shoulder Problems
- ___ Arm Problems
- ___ Numb - Arms/Fingers
- ___ Pain Bewtween Shoulders
- ___ Low Back Problems
- ___ Leg Problems
- ___ Numbness - Legs/Toes
- ___ Loss of Feeling
- ___ Stiff Joints
- ___ Painful Joints
- ___ Sore Muscles
- ___ Muscle Cramps
- ___ Broken Bones

Neurological
- ___ Weak Muscles
- ___ Dizziness
- ___ Memory Problems

Mental / Emotional
- ___ Extreme Worry
- ___ Depression
- ___ Anxiety
- ___ Insomnia
- ___ Vision Problems
- ___ Ear Infection
- ___ Ear Pain/Noises
- ___ Hearinng Loss R. L.
- ___ Frequent Colds / Flu
- ___ Fatigue / Low Energy

Past History
- ___ Allergies/medications _____
- ___ Sinus / Hay Fever
- ___ Asthma / Bronchitis
- ___ Heart Problems
  Angina, MI, CAD, COPD, CHF
- ___ Blood Pressure High / Low
- ___ Kidney Problems
- ___ Indigestion or Nausea
- ___ Ulcers
- ___ Skin Problems
- ___ Constipation
- ___ Diarrhea / Constipation
- ___ Diabetes / Blood Sugar Problem
- ___ Menstrual Cramps / PMS

ADL _____ Restricts Daily Activities _____ Restricts Regular Exercise _____ Difficulty Walking/Standing Sitting

Household duties _____

Surgeries/Hospitalizations _____

_____

Have you had and MRI/CT Scan? _____ Dates _____

Previous Chiropractic Care _____

Date of last adjustment _____

• Female: Are you pregnant at this time? ☐ Yes ☐ No Due Date _____

Do you have a pacemaker? ☐ Yes ☐ No

TRAUMA FROM BIRTH TO PRESENT PLEASE LIST BY DATE/DESCRIBE

1) Injuries or Falls _____

2) Broken Bones _____

3) Car/Bike Accidents _____

Do you have any metal in your body? ☐ Yes ☐ No

If yes, where? _____

Sign & Date: _____

(FOR DOCTORS USE ONLY)

CERVICAL	Norm	Date 1____	2____	3____	4____
Flexion	50				
Extension	60				
Lat. R. Flex	45				
Lat. L. Flex	45				
Rotation Right	80				
Rotation Left	80				

LUMBAR	Norm	Date 1____	2____	3____	4____
Flexion	60				
Extension	25				
Lat. R. Flex	25				
Lat. L. Flex	25				
Rotation Right	30				
Rotation Left	30				

CS _____
CT _____
CR _____
TS _____
TT _____
TR _____
PS _____
PT _____
PR _____

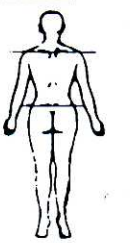
_____

_____

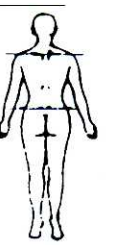
Dynanometer _____

1____		2____		3____		4____	
L	R	L	R	L	R	L	R

1_____ 2_____



3_____ 4_____



Comments _____

_____

_____

Height _____ Weight _____