Case No. _____

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 _____ Phone _____ 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?

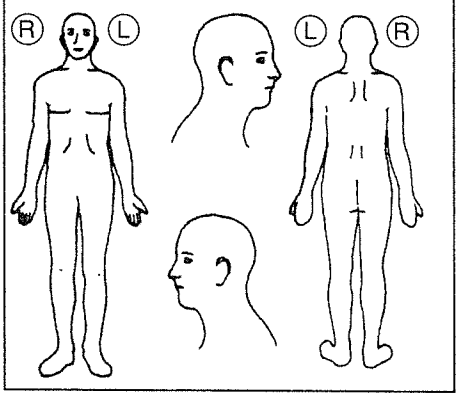
1. Difficulty In Performing Basic Activities of Daily Living - ☐ Bathing/showering ☐ Shaving ☐ Dressing
2. Daily duties: Diffficulty In Performing - ☐ Cleaning ☐ Washing Dishes ☐ Sweeping/Mopping
3. Hobbies: Slowing Or Prevention Of Certain Hobbies _____
4. Work: ☐ I Just Get Through = Slower Production 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? _____ **Who is your primary care physician?** _____

Please mark your areas of pain on the figures below.



Mark any other symptoms 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 Between Shoulders
___ Low Back Problems
___ Leg Problems
___ Numbness - Legs/Toes
___ Loss of Feeling
___ Stiff Joints
___ Painful Joints
___ Sore Muscles
___ Muscle Cramps

Neurological
___ Weak Muscles
___ Dizziness
___ Memory Problems

Mental / Emotional
___ Extreme Worry
___ Depression
___ Anxiety
___ Insomnia
___ Vision Problems
___ Ear Infection
___ Ear Pain/Noises
___ Hearing 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
___ Diarrhea / Constipation
___ Diabetes / Blood Sugar Problem
___ Menstrual Cramps / PMS
___ IBS
___ Crohns
___ Stomach Problems
___ Acid Reflux/Heartburn
___ Cancer
___ History of Cancer

Disease: _____ HIV/Hep. B _____ TB _____ Mrsa

Surgeries/Hospitalizations _____

_____

Have you had a 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				

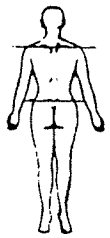
LUMBAR	Norm	Date 1	2	3	4
Flexion	60				
Extension	25				
Lat. R. Flex	25				
Lat. L. Flex	25				
Rotation Right	30				
Rotation Left	30				

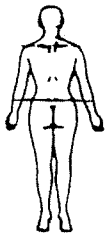
CS _____
CT _____
CR _____
TS _____
TT _____
TR _____
PS _____
PT _____
PR _____

Dynanometer

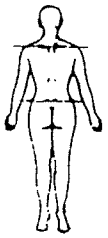
1		2		3		4	
L	R	L	R	L	R	L	R

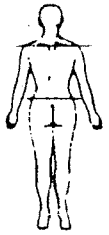
1 _____ 2 _____





3 _____ 4 _____





Comments _____

_____

_____

Foot Levelers:

Date _____ P.I.R. _____

Pulse _____ Temp _____

BP _____ SPO2 _____

HEALTH HISTORY OF FAMILY MEMBERS

The reason for this form is to assist the doctor by providing past health history information for his review.

Condition	Self	Father	Mother	Spouse	Brothers	Sister	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Drinker							
Drug Addiction							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraines							
Nervousness							
Neuritis							
Neuralgia							
Obesity							
Pinched Nerve							
Sinus Trouble							
Smoker							
Sports Activities							
Stomach Trouble							
Deceased							

Name:_____ Signature:_____ Date:_____