

Chiropractic & Wellness Center, PC

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
DOB _____ SS# _____ Marital Status: S M D W Sex: M/F Age _____
Occupation _____ Employer _____
Work Address _____
If applicable:
Parents/Legal Guardians Name _____
Address _____
Home Phone _____ Work Phone _____
No. of Children _____ How did you hear about our office? _____

Main Complaint

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____

3. What is your treatment goal? _____
4. If this is a recurrence, when was the first time you noticed the problem? _____
5. How did it originally occur? _____
6. Has it become worse recently? Yes _____ No _____ Same _____ Gradually Worse _____
If yes, when and how? _____
7. How frequent is this condition? Constant _____ Daily _____ Intermittent _____ Night Only _____
8. How long does it last? All Day _____ Few Hours _____ Minutes _____
9. How many days have you lost from work due to these symptoms? _____
10. Are there any other conditions or symptoms that may be related to your major symptoms
Yes _____ No _____. If yes, describe _____
11. Are there other related health problems? Yes _____ No _____. If yes, describe _____
Describe the pain: Sharp _____ Dull _____ Numbness _____ Tingling _____ Aching _____ Burning _____
Stabbing _____ Other _____
12. Is there anything you can do to relieve the problem? Yes _____ No _____.
If yes, Describe _____
If no, what have you tried to do that has not helped? _____

13. What makes the problem worse? Standing _____ Sitting _____ Lying _____ Bending _____ Lifting _____ Twisting _____
Other _____
14. Have you had any broken bones? Yes _____ No _____. If yes, please list and give dates _____
15. List any major accidents you have had other than those that might be mentioned above _____

16. To your knowledge, have you had any disease, major illnesses, or injuries not indicated on this form either in past or
the present? _____
17. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes _____ No _____ Uncertain _____
Remarks: _____

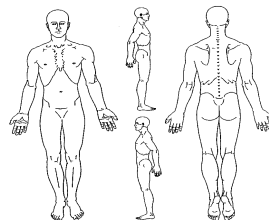
NO PAIN

Unbearable Pain

[_____]

Please place an "X" on the line above to indicate level of problem

Show area(s) of
pain, discomfort
or unusual
feeling



Medical History

Past Chiropractic care / doctor's name _____
Family physician _____ Medications _____
Surgeries / dates _____
Illness / abnormalities _____
Previous Injuries & accidents / dates _____

Do you have any difficulty with any of the following?

- Headaches, Shooting head pains, Sinus Trouble, Loss of smell, Hayfever, Asthma/allergies, Loss of taste, Tightness in throat, Inflammation of throat, Thyroid Trouble, Face flushed, Twitching of face, Loss of memory, Fatigue, Depression, Head feels too heavy, Weight gain, Fainting, Loss of balance, Ringing in ears, Dizziness, Light bothers eye, Muscle spasms in neck, Grating in neck, Tightness of shoulder muscles, Neuritis in shoulders & arms, Pins & needles in hand, Cold hands, Chest pains, Shortness of breath, Heart attacks, Heart pain, Heart palpitations, Weight loss, High Blood pressure, Low Blood pressure, Anemia, Rheumatic Fever, Nervous Stomach, Stomach Trouble, Ulcers, Nerves & Nervousness, Inner tension, Irritability, Cold sweats, Liver trouble, Gall Bladder trouble, Indigestion, Intestinal gas, Constipation, Bladder trouble, Menstrual cramps & pain, Menstrual Irregularity, Diabetes, Cancer, Sleeping problems, Painful joints, Swollen joints, Arthritis, Slipped disc, Pinched nerves in back, Pins & needles in legs, Swollen ankles, Cold feet, Pains in legs & feet, Kidney Trouble

Family Medical History

- Breast Cancer, Osteoporosis, Alzheimer's, Other Cancers, Alcoholism, Diabetes, Cardiovascular disease, Mental Illness/depression, Arthritis, Stroke, Obesity, Allergies

Please place an "F" for father or father's side or "M" for mother's side of the family in front of anything you marked in the section above

Lifestyle and Diet

Rate your current level of stress on a scale of 1 to 10 (1=low): 1 2 3 4 5 6 7 8 9 10

What are major causes? Work Family Finances Relationships Emotions
Other _____

I eat the following: Sweets Sodas/Pop Ice Cream Fried Foods
Cereals Legumes Fruits Vegetables

List your 4 favorite foods: _____

This applies to me: Diet frequently Skip meals Dine out regularly
Eat (0 1 2 3 4 5 6 more) meals a day

When do you eat? Morning Noon Night Constantly snacking

Do you:

- Use tobacco? YES or NO If yes, how much daily? _____
If no, did you ever? YES or NO if yes how much? _____
-Have exposure to second hand smoke? YES or NO If yes, how much daily? _____
If no, did you ever? YES or NO if yes how much? _____
-Drink Coffee? YES or NO If yes, how much daily? _____
If no, did you ever? YES or NO if yes how much? _____
-Eat Chocolate? YES or NO If yes, how much daily? _____
-Drink Alcohol? YES or NO If yes, how many ounces a day/week? _____
If no, did you ever? YES or NO if yes how much? _____
How long did you drink before you stopped? _____
-Restrict your intake or avoid completely:
Fiber Salt Sugar Fat
Dairy products Animals protein All animal foods Other

Exercise

Exercise weekly? YES or NO If yes, how many times per week? _____

I agree that the information I provided is correct _____