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?

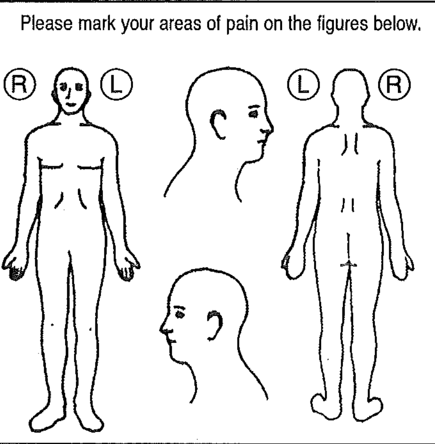
1. Difficulty In Performing Basic Activities of Daily Living - ☐ Bathing/showering ☐ Shaving ☐ Dressing
2. Daily duties: Diffficulty In Performing - ☐ Cleaning ☐ Washing Dishes ☐ Sweeping Mopping
3. Hobbies: Slowing Or Prevention Of Certain Hobbies ______________________________
4. Work: ☐ I Just Get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

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

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
___ Diarrhea / Constipation
___ Diabetes / Blood Sugar Problem
___ Menstrual Cramps / PMS
___ IBS
___ Chrons
___ 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? ______________________________

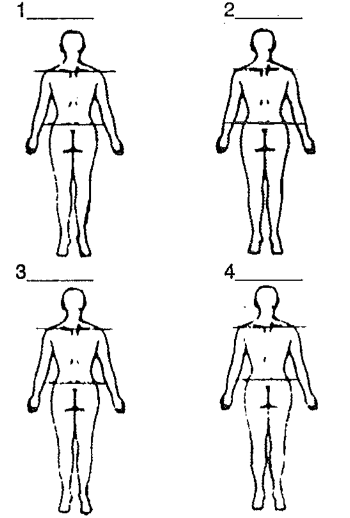
Sign & Date: ______________________________

(FOR DOCTORS USE ONLY)

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

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

	1____ L	1____ R	2____ L	2____ R	3____ L	3____ R	4____ L	4____ R
CS								
CT								
CR								
TS								
TT								
TR								
PS								
PT								
PR								
Dynanometer								



Comments ______________________________

____

Foot Levelers: ______________________________

Date ________ P.I.R. ________

Pulse ________ Temp ________

BP ________ SPO_2 ________

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:________________