

Date \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

Patient Name \_\_\_\_\_  
last name first name middle

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Ph \_\_\_\_\_

Email \_\_\_\_\_ May we add you to our email list?  Yes  No We do not share your information with anyone.

Sex  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_  
 Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Birth date \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Cell ph \_\_\_\_\_ Home ph \_\_\_\_\_

**PATIENT CONDITION**

Reason for visit \_\_\_\_\_

Is your condition due to an accident?  Yes  No Type of accident:  Auto  Work  Home  Other

To whom have you made a report of your accident?  Auto Ins  Employer  Worker Comp  Other

When did your symptoms first appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

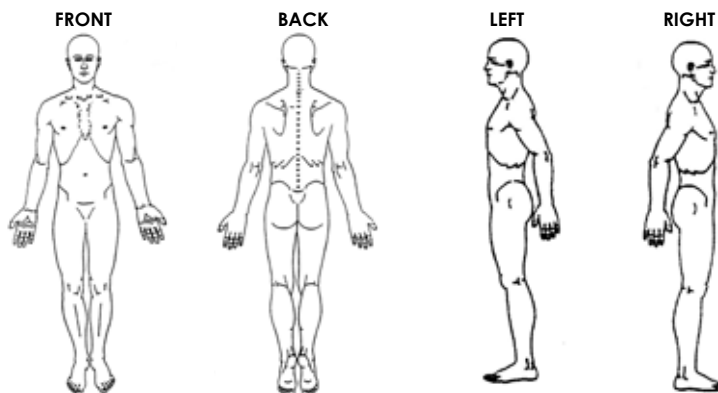
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_ Pain frequency is:  Constant  Occasional

Does the pain interfere with any of the following?  Work  Sleep  Daily routine  Recreation

Activities or movements that are painful to perform:  Sitting  Standing  Walking  Bending  Lying down

Please mark an X on the picture to the right where you continue to have pain, numbness and/or tingling.



# HEALTH HISTORY

## What treatment(s) have you already received for your condition?

Medications  Surgery  Physical Therapy  Chiropractic  None  Other \_\_\_\_\_

## Name and Address of other doctor(s) that have treated you for this condition:

Dr. Name \_\_\_\_\_ Address \_\_\_\_\_ Ph \_\_\_\_\_

Dr. Name \_\_\_\_\_ Address \_\_\_\_\_ Ph \_\_\_\_\_

Dr. Name \_\_\_\_\_ Address \_\_\_\_\_ Ph \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI \_\_\_\_\_ CT-Scan \_\_\_\_\_ Bone Scan \_\_\_\_\_

## Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |  |   |   |   |
|--|---|---|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No            | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No        | Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No   | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No          | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No         | Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No          | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No       | Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No        | Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No        | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No              | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No         | Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No   | Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No            | Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No           | Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No                | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No        | Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No        | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No         | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No        |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No           | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No             | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No            | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No              | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No    | Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No  | Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No  | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No        | Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No        | Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No         | Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No           | Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No            | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No          | Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No   | Polio <input type="checkbox"/> Yes <input type="checkbox"/> No                | Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No             | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No           | Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No     | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No              | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No           | Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No           | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No   | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No     | Other _____   |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No    | Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No         | Measles <input type="checkbox"/> Yes <input type="checkbox"/> No          |   |   |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No            |   |   |   |

### EXERCISE

- None  
 Moderate  
 Daily  
 Heavy

### WORK ACTIVITY

- Sitting  
 Standing  
 Light Labor  
 Heavy Labor

### HABITS

- Smoking  
 Alcohol  
 Coffee/Caffeine Drinks  
 High Stress Level

Packs/Day \_\_\_\_\_  
Drinks/Week \_\_\_\_\_  
Cups/Day \_\_\_\_\_  
Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

## Injuries/Surgeries you have had:

	Description	Date
Head injuries	_____	_____
Broken bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy _____	_____	_____
Pharmacy ph. _____	_____	_____

Mark below any of the following symptoms you have experienced in the past 6 months.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Low Back Pain                | <input type="checkbox"/> Shoulder Pain       | <input type="checkbox"/> Weight Trouble                      |
| <input type="checkbox"/> Neck Pain                    | <input type="checkbox"/> Hip Pain            | <input type="checkbox"/> Tension Across the Top of Shoulders |
| <input type="checkbox"/> Pain Between Shoulder Blades | <input type="checkbox"/> Knee Pain           | <input type="checkbox"/> Tingling / Numbing in Arms or Hands |
| <input type="checkbox"/> Tension / Headaches          | <input type="checkbox"/> Ankle / Foot Pain   | <input type="checkbox"/> Tingling / Numbing in Legs or Feet  |
| <input type="checkbox"/> Tired or Fatigued            | <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> Dizziness                           |
| <input type="checkbox"/> Wrist / Hand Pain            | <input type="checkbox"/> Allergies           | <input type="checkbox"/> Nervousness                         |
| <input type="checkbox"/> Elbow Pain                   | <input type="checkbox"/> Digestive Troubles  | <input type="checkbox"/> Difficulty Sleeping                 |

Which one of the above symptom(s) is worse? \_\_\_\_\_

How long have you had the symptom(s) ? \_\_\_\_\_

When it is at its worst, how does it feel? \_\_\_\_\_

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Mark below how the symptom(s) cause you to act.

- Moody    Irritable    Interrupts Sleep    Restrict daily activities    Other \_\_\_\_\_

Mark below how the symptom(s) affect you at work.

- Decision making    Exhausted at end of day    Decreased productivity  
 Poor attitude    Unable to work long hours    Other \_\_\_\_\_

Mark below how the symptom(s) affect you at home.

- Lose patience with others  
 Hinders ability to exercise or participate in sports  
 Restricted household duties  
 Interferes with ability to participate in hobbies or other desired activities  
 Other \_\_\_\_\_

What have you done that aggravates the problem and/or what have you failed to do that could have helped alleviate it?

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If your problem was left untreated for five years, how do you think it would affect you?

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Are you committed to getting rid of, not only your symptom(s), but what caused them, even if it requires a change in your lifestyle?  Yes    No

If no, why not? \_\_\_\_\_

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