PATIENT CONDITION

Describe your major complaint(s):_____

_____

Date you first noticed symptoms:_____ Describe how they began:_____

_____

Have you had these symptoms before? YES NO If yes, when:_____

How often do you experience the symptoms?

Constantly (76%-100% of the day)
Frequently (51%-75% of the day)
Occasionally (26%-50% of the day)
Intermittently (0%-25% of the day)

How would you describe the symptoms?

Sharp	Shooting	Stabbing	Weakness
Dull	Burning	Stiffness	Throbbing
Numb	Tingling	Cramps	Achy

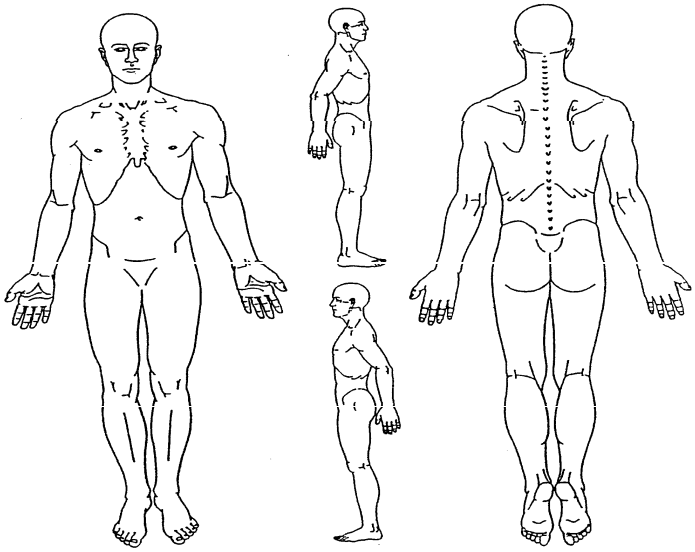
How are your symptoms changing?

Getting Better Getting Worse No Change

How would you rate your symptoms at their:

	None									Unbearable
Best:	0	1	2	3	4	5	6	7	8	9 10
Worst:	0	1	2	3	4	5	6	7	8	9 10

PLEASE MARK BELOW WHERE YOU HAVE SYMPTOMS



How do your symptoms affect your ability to perform daily activities?

0	1	2	3	4	5	6	7	8	9	10
No Complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible

What makes your symptoms worse?_____

What makes your symptoms better?_____

Have you seen any other health care professionals for this condition? YES NO If yes, list the providers:

Name: Address: Date:

____ _____

____ _____

Have you had any tests done for your symptoms? YES NO If yes, please check test and give date.

X-Rays_____ CT Scan_____ MRI_____ Lab_____ Other_____

Please indicate findings if known:_____

Have you seen any other health care professionals for any other condition? YES NO If yes, please list:

Name: Address: Date:

____ _____

____ _____

Have you ever received chiropractic care before? YES NO If yes, please list:

Name: Dates: Type of Chiropractic (Manual/Used Hands, Activator, Blocking, Drop Table, etc)

_____

_____

HEALTH HISTORY

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

AIDS/HIV	Yes	No	Dizziness	Yes	No	Hypertension	Yes	No	Psychiatric Care	Yes	No
Alcoholism	Yes	No	Eating Disorder	Yes	No	Kidney Disease	Yes	No	Rheum. Fever	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Liver Disease	Yes	No	Ringing in Ears	Yes	No
Ankle Swelling	Yes	No	Excessive Thirst	Yes	No	Loss of Balance	Yes	No	Shortness of		
Arthritis	Yes	No	Fainting	Yes	No	Loss of Sleep	Yes	No	Breath	Yes	No
Asthma	Yes	No	Fatigue	Yes	No	Miscarriage	Yes	No	Stroke	Yes	No
Bleeding			Fever	Yes	No	Mononucleosis	Yes	No	Thyroid		
Disorder	Yes	No	Fractures	Yes	No	Multiple			Problem	Yes	No
Bowel/Bladder			General			Sclerosis	Yes	No	Tuberculosis	Yes	No
Changes	Yes	No	Stiffness	Yes	No	Nausea	Yes	No	Tumors	Yes	No
Breast Lump	Yes	No	Glaucoma	Yes	No	Night Sweats	Yes	No	Ulcers	Yes	No
Cancer	Yes	No	Goiter	Yes	No	Numbness	Yes	No	Unintentional		
Chemical			Gonorrhea	Yes	No	Osteoporosis	Yes	No	Weight Change	Yes	No
Dependency	Yes	No	Gout	Yes	No	Pacemaker	Yes	No	Vaginal		
Chest Pain	Yes	No	Headaches	Yes	No	Pinched Nerve	Yes	No	Infections	Yes	No
Chronic Cough	Yes	No	Heartburn	Yes	No	Pins / Needles			Venereal		
Cold Limbs	Yes	No	Heart Problem	Yes	No	Feeling in Limbs	Yes	No	Disease	Yes	No
Depression	Yes	No	Hernia	Yes	No	Pneumonia	Yes	No	Visual Problem	Yes	No
Diabetes	Yes	No	Herniated Disc	Yes	No	Polio	Yes	No	Vomiting	Yes	No
Diarrhea	Yes	No	Herpes	Yes	No	Prostate			Other_____		
Digestive			High			Problem	Yes	No	_____		
Problem	Yes	No	Cholesterol	Yes	No	Prosthesis	Yes	No	_____		

EXERCISE

None
Moderate
Daily
Heavy

WORK ACTIVITY

Sitting
Standing
Light Labor
Heavy Labor

HABITS

Smoking Packs / Day_____
Alcohol Drinks / Week_____
Caffeine Cups / Day_____
High Stress Reason_____

Are you pregnant? YES NO Due Date_____

INJURIES / SURGERIES / ACCIDENTS

Description Date

Falls:_____ ___ _____
Head Injuries:_____ _____
Broken Bones:_____ _____
Dislocations:_____ ___ _____
Surgeries (Including Cosmetic):_____ _____
Automobile Accidents:_____ _____

MEDICATIONS

_____ ____
_____ ____
_____ ____

ALLERGIES

_____
_____
_____

VITAMINS / HERBS / SUPPLEMENTS

_____
_____
_____