WELCOME

1 one — REASON FOR VISIT

Reason for today's visit: ❑ Emergency ❑ New injury ❑ Old injury ❑ Chronic pain ❑ Wellness

Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense

Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity

When did your condition/accident occur? ___/___/___ Where did your injury occur? ______________________

Please explain what happened: ______________________

Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes.

Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how: ______________________

____

Has this or something similar happened in the past?

❑ Yes ❑ No Explain: ______________________

____

Using the adjacent body charts, please circle all affected areas.

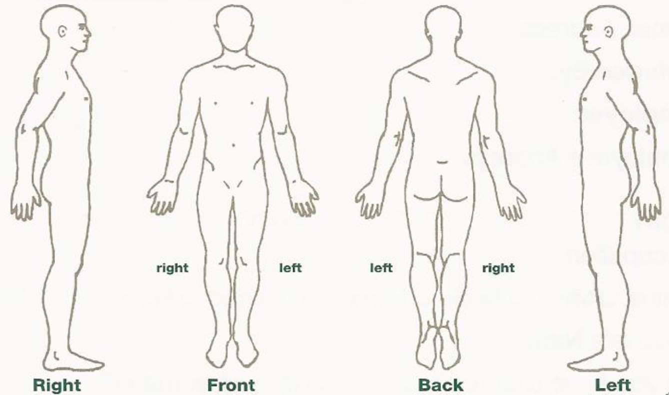
Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? ______________________

____

Have you ever been treated by a Chiropractor? ❑Yes ❑No

Clinic or Dr's name: ______________________

Clinic phone#: ______________________



©

2 two — HEALTH HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) ______________________

____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Murmur	**Y N** Congenital Heart Defect	**Y N** Mitral Valve Prolapse
Y N Artificial Valves	**Y N** Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis	**Y N** HIV+ / AIDS / ARC
Y N Shingles	**Y N** Cancer	**Y N** Frequent Neck Pain	**Y N** Glaucoma	**Y N** Anemia / Diabetes
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever	**Y N** Severe / Frequent Headaches	**Y N** Kidney Problems
Y N Ulcers / Colitis	**Y N** Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Emphysema / Asthma	**Y N** Tuberculosis
Y N Difficulty Breathing	**Y N** Chemotherapy	**Y N** Lower Back Problems	**Y N** Artificial Bones/Joints/Implants	**Y N** Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: ______________________

____

List any past serious accidents with dates: ______________________

Please list anything that you may be allergic to: ______________________

Family Health History: ______________________

Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you exercise? ❑ No ❑ Yes _____ hours per week

Do you smoke? ❑ No ❑ Yes How much? ____________ How long? ________

Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting: ❑No ❑Yes Since: ___/___/___

For woman: Are you taking Birth Control? ❑ Yes ❑ No Are you taking Hormonal Replacement? ❑ Yes ❑ No

Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks? ____________

©

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

PLEASE CONTINUE ON BACK