Name ______________________ Address ______________________

City ______________ State __________ Zip ______ Home Phn ______________

Cell Phn ____________ Pager ______________ E-mail Home ______________

SSN ______________ Date of Birth ____________ Age ______ Height ______ Weight ______

Male ☐ Female ☐ Single☐ Married☐ Divorced ☐ # Of Children______ Spouse Name ______________

How were you referred to our office? ______________________

Employer______________________ Address______________________

City ____________ State ______ Zip ______ Wk Phn ________ Occupation ______________

Have you ever had Chiropractic care before? ________ If yes, when? ______________

If you are experiencing any health problems, please list your chief complaints in order of severity

1______________________ For how long? ______________

2______________________ For how long? ______________

3______________________ For how long? ______________

List other doctors consulted for these conditions: ______________________

Name of family physician______________________

Do you ever experience any of these complaints while working? _______ If yes, describe what activities at work that may be causing you to experience these complaints: ______________________

____

____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? ______If yes, please explain: ______________________

____

____

If this is due to an injury or accident, what is the date of the injury? ______________

Has this problem been getting better, worse, or staying the same? ______________

What activities make your conditions worse? ______________________

Have you ever had any surgeries or hospitalizations? ______If yes, please list:______________

Please list any injuries or illnesses that you have had that are not listed above: ______________

Please indicate medications (over the counter) / prescriptions you are currently taking: ☐Aspirin/Tylenol

☐ Pain Killers ☐Muscle relaxers ☐ Insulin ☐ Tranquilizers ☐Birth Control Pills ☐ Others ____________

Have you been involved in an auto accident in the last 12 months? __________ If yes, when? ______________

Health insurance ______________________ Policy Holder ______________________

Claims address______________________ Policy Holder______________________

Spouse's health insurance ______________ Policy Holder ______________________

Claim's address______________________ Policy Holder ______________________

IMPORTANT: Please check (X) all present symptoms.

HEAD:
- ❑Headache
  - ❑sinus (allergy)
  - ❑entire head
  - ❑back of head
  - ❑forehead
  - ❑temples
  - ❑migraine
- ❑Head feels heavy
- ❑Loss of memory
- ❑Light-Headedness
- ❑Fainting
- ❑Light bother eyes
- ❑Blurred vision
- ❑Double vision
- ❑Loss of vision
- ❑Loss of taste
- ❑Loss of balance
- ❑Dizziness
- ❑Loss of hearing
- ❑Pain in ears
- ❑Ringing in ears
- ❑Buzzing in ears

NECK:
- ❑Pain in neck
- ❑Neck pain with movement
  - ❑forward
  - ❑backward
  - ❑turn to left
  - ❑turn to right
  - ❑bend to left
  - ❑bend to right
- ❑Pinched nerve in neck
- ❑Neck feels out of place
- ❑Muscle spasms in neck
- ❑Grinding sounds in neck
- ❑Popping sounds in neck
- ❑Arthritis in neck

ARMS AND HANDS:
- ❑Pain in upper arm
- ❑Pain in elbow
- ❑Movement aggravated
- ❑Tennis elbow
- ❑Pain in forearm
- ❑Pain in hands
- ❑Pain in fingers
- ❑Sensation of pins and needles in arms
- ❑Sensation of pins and needles in fingers
- ❑Numbness in arms (R-L)
- ❑Fingers go to sleep
- ❑Hands cold
- ❑Swollen joints in fingers
- ❑Sore joints in fingers
- ❑Arthritis in fingers
- ❑Loss of grip strength

SHOULDERS:
- ❑Pain in shoulder joint (R-L)
- ❑Pain across shoulders
- ❑Bursitis (R-L)
- ❑Arthritis (R-L)
- ❑Can't raise arm
  - ❑above shoulder level
  - ❑over head
- ❑Tension in shoulders
- ❑Pinched nerve in shoulder (R-L)
- ❑Muscle spasms in shoulders

MID BACK:
- ❑Mid-back pain
- ❑Location _______________________
- ❑Pain between shoulder blades
- ❑Sharp stabbing
- ❑Dull ache
- ❑Pain from front to back
- ❑Muscle spasms
- ❑Pain in kidney area

CHEST:
- ❑Chest pain
- ❑Shortness of breath
- ❑Pain around ribs
- ❑Breast pain
- ❑Dimpled or orange peel breast
- ❑Irregular heartbeat

ABDOMEN:
- ❑Nervous stomach
- ❑Foods can't eat ________________
- ❑Nausea
- ❑Gas
- ❑Constipation
- ❑Diarrhea
- ❑Hemorrhoids

LOW BACK:
- ❑Low back pain
- ❑Upper lumbar
- ❑Lower lumbar
- ❑Sacroiliac
- ❑Low back pain in worse when:
  - ❑working
  - ❑lifting
  - ❑stooping
  - ❑standing sitting
  - ❑bending
  - ❑coughing
  - ❑lying down (sleeping)
  - ❑walking
- ❑Pain relieved with: ______________
- ❑Slipped disk
- ❑Low back feels out of place
- ❑Muscle spasms
- ❑Arthritis

HIP, LEGS, AND FEET:
- ❑Pain in buttocks
- ❑Pain in hip joint
- ❑Pain down leg
- ❑Pain down both legs
- ❑Knee pain
  - ❑inside
  - ❑outside
- ❑Leg cramps
- ❑Crams in feet
- ❑Pins and needles in legs
- ❑Numbness of leg
- ❑Numbness of toes
- ❑Feet feel cold
- ❑Swollen ankles
- ❑Swollen feet

WOMEN ONLY:
- ❑Cramping
- ❑Hysterectomy
- ❑Menopause
- ❑Tumors
- ❑Are you or do you think you are pregnant?

MEN ONLY:
- ❑Urinary frequency ______________
- ❑Difficulty in starting
- ❑Night urination
- ❑Prostrate pain/swelling

GENERAL:
- ❑Nervousness
- ❑Irritable
- ❑Depressed
- ❑Fatigue
- ❑Generally feel run-down
- ❑Normal sleep hrs/night ___________
- ❑Loss of sleep hrs/night ___________
- ❑Loss of weight lbs ______________
- ❑Gain weight lbs ________________
- ❑Coffee cups/day ________________
- ❑Tea cups/day __________________
- ❑Cigarettes pack/day _____________
- ❑Other _________________________
- ❑Diabetes
- ❑Hypoglycemia

REMARKS:

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