Personal Information

Name: ____ ________
Address____
City ____ State ________ Zip: ___________

Birth Date:____________ Gender: ❍ M ❍ F Marital Status: ❍ S ❍ M ❍ D ❍ W

Home Phone: ____________________Mobile Phone: ______________________
Email address________________________ Occupation_________________________

How were you referred to "our office"? ______________

What is your major area (Pain) complaint(s) ? _________________________________
When and how did it begin , Fall lifting ect?____

Please shape in area of pain on drawing

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(
0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How often do you experience your 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)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: ____

Have you seen another doctor for this condition? ❍ Yes ❍ No
If yes Doctor name/ diagnosis____________________________

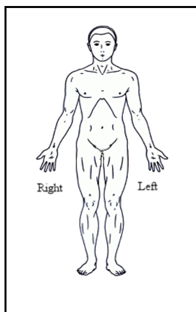
What **activities aggravates** this condition? **Check those activities below during which you experience difficulty or pain**:

❍ Lying on back ❍ Lying on side ❍ Turning over in bed ❍ Lying flat on stomach
❍ Getting in / out of car ❍ Dressing Self ❍ driving ❍ Pushing
❍ Pulling ❍ Reaching ❍ Kneeling ❍ Stooping
❍ Sitting ❍ Bending forward ❍ Bending backward ❍ Walking
❍ Standing long periods ❍ Sneezing ❍ Coughing
Other:____

Does this condition interfere with your sleep? ❍ Yes ❍ No If yes, how many times do you wake up in pain per night? ________________

In what position do you sleep? ❍ Back ❍ Side ❍ Stomach
Do you sleep with a pillow? ❍ Yes ❍ No If yes How many?________

Have you ever had any surgeries or hospitalizations in last 2 years? ❍ Yes ❍ No
Type of Hospitalization/Surgery: ____Date: _____



Have you ever been seen by a chiropractor before? ❍ Yes ❍ No
Name of chiropractor: __________________________Date: ______________

Do you have a family physician? ❍ Yes ❍ No Name of physician: _____________________________________

List all medication (including over the counter) and vitamins you are taking now:

____
____
__

Any Additional Complaints:

❍ neck pain ❍ mid back pain ❍ low back pain ❍ other ________________________

Do you get headaches? ❍ Yes ❍ No If yes Frequency _______ per week.
Do you experience the following along with your headaches:
Nausea, Vomiting or Visual disturbances? ❍ Yes ❍ No
Do you feel pressure or pain behind your eyes? ❍ Yes ❍ No

Do you hear grating sounds in your neck when you move it? ❍ Yes ❍ No
Does pain radiate into the arm? ❍ Yes ❍ No Where? ____________________________________

Please check all additional medical history:

❍ Loss of Concentration ❍ Eyes Sensitive to Light ❍ Memory Loss
❍ Heavy Feeling of Head
❍ Dizziness ❍ Ringing in Ears ❍ Loss of Balance ❍ Loss of Smell
❍ Loss of Taste ❍ Pain Behind Eyes ❍ Vision Problems ❍ Fainting
❍ Neck Motion Restricted ❍ Neck Stiffness ❍ Sinus Trouble ❍ herniated disc
❍ Upper Back Pain / Stiff ❍ Right / Left Shoulder Pain ❍ ❍ Leg Pain
❍ Pins & Needles Arms /Legs ❍ Nervousness ❍ Chest Pain ❍ Palpitation
❍ Shortness of Breath ❍ Irritable ❍ Anxiety ❍ Depression
❍ epidural injections ❍ Insomnia ❍ Fatigue ❍ Digestive Trouble
❍ Nausea ❍ Vomiting ❍ Diarrhea ❍ Constipation
❍ Cold Hands ❍ Cold Feet ❍ Jaw Pain ❍ Hypertension

❍ Diabetes ❍ Convulsions ❍ Anemia ❍ Heart Disease
❍ Arthritis ❍ HIV (Aids) ❍ Cancer

Allergies:
❍ Seasonal ❍ Mold ❍ Dust❍ Dairy ❍ Wheat ❍ other ____________________

Surguries in last 2 years : ____

Do you have, or have you ever had, any diseases or medical problems not listed? ❍ Yes ❍ No
If so, please list: ____
____

If you have any questions concerning this form or the above statements, please ask the doctor. Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date________ Patient's Signature____