

Patient Name _____ **Date** _____

Please list your major health problems/concerns and when you first noticed them:

1. _____
2. _____
3. _____
4. _____

If your condition involves pain, please characterize type and draw:

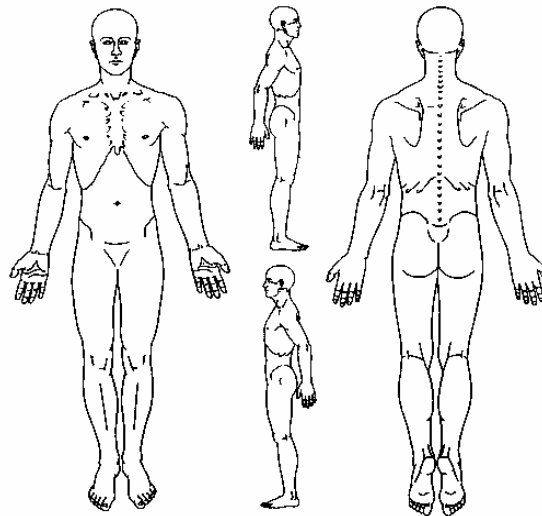
- Ache
 Sharp
 Radiating
 Constant
 Intermittent

Any other comments:

What makes it worse:

What makes it better:

0 10
 ☺ Pain Scale ☹



Please underline any conditions you have had in the past and circle any you currently have.

AIDS	Congestive Heart Failure	HIV positive	Psychiatric care
Alcoholism	Depression	Joint replacement	Rheumatic Fever
Anemia	Diabetes	Kidney Disease	Rheumatoid arthritis
Anorexia	Eczema	Liver Disease	Scarlet fever
Anxiety	Emphysema	Measles	Sexually transmitted disease
Appendicitis	Epilepsy	Migraines	Sinus Problems
Arthritis	Glaucoma	Miscarriage	Stroke
Asthma	Gonorrhea	Mononucleosis	Suicide thoughts/attempt
Bleeding Disorders	Gout	Multiple Sclerosis	Thyroid problems
Blood in urine	High blood pressure	Mumps	Tonsillitis
Breast Lump	Heart murmur	Panic Attacks	Tuberculosis
Bronchitis	Hepatitis	Pacemaker	Ulcers
Bulimia	Hernia	Pneumonia	Unconsciousness
Cancer	Herpes	Polio	Vaginal Infections
Cataracts	Hiatal Hernia	Post Partum Blues	Other:
Coma	High Cholesterol	Psoriasis	

Please list and date ANY:

Surgeries/ Procedures: _____

Accidents/ Serious Injuries: _____

Broken Bones/ Dislocations: _____

Have you ever had spinal x-rays MRI CT For what? _____

Current Family Physician: _____ Phone _____

Medications (purpose) / Herbs / Supplements (please include brand)

Work Habits: Sitting Standing Light labor Heavy labor _____

Do You Smoke? No Yes Packs/ Day _____

Amount of water you drink each day _____ Your weight _____ lbs Your height _____

Review of Systems

Please underline any conditions you have had in the past and circle any you currently have.

General	Cardiac/vascular	GU	Cold intolerance
Fever	Chest pain	Bladder control	Hair falling out
Chills	Chest pressure	Blood in urine	Excessive thirst
Night Sweats	Fainting	Decrease force or urine	Heme/lymph
Weight Loss	Heart murmur	Painful intercourse	Easy bruising
Fatigue	High blood pressure	Painful urination	Bleeding gums
Loss of energy	Irregular heart beat	Pelvic pain	Lymph nodes
Loss of sleep	Leg pain when walk	Sexual dysfunction	Allergies/Immun
Eye	Lightheaded	Urinary hesitancy	Seasonal allergies
Blurred vision	Low blood pressure	Neurology	Other allergies
Double vision	Pass out	Cold or numb hands/feet	Other symptoms not covered:
Crossed-lazy eye(s)	Palpitations	Convulsions (seizures)	
Eye pain	Phlebitis	Frequent headaches	
Loss of vision	Poor circulation	Muscle weakness	
Visual Flashes	Shortness of breath	Numbness/tingling	
Visual Halos	At rest	Tremors	
Had laser surgeries	With exertion	Unsteady walking	Female only
Wear glasses or contacts	Lying flat	Vertigo/spinning	# of pregnancies:
Ear, Nose, Throat	Swollen ankles	Psychosocial	# of live births:
Decreased hearing	Varicose Veins	Anxiety	# of miscarriages/abortions:
Earache	Pulmonary	Depression	# vaginal deliveries :
Ear discharge	Cough	Nervousness	# C-sections :
Ear fullness	Wheezing	Skin/breast	Birth control? / type:
Ear infections	Gastrointestinal	Eczema	Periods are:
Ear ringing-buzzing	Abdominal pain	Hives	Regular
Hoarseness (prolonged)	Black stools	Itching	Irregular
Jaw Clicking	Bloating	Rashes	Painful
Jaw locking	Blood in stools	Yellow skin/eyes	
Nosebleeds	Constipation	Breast lumps	Pregnant Now?
Post nasal drip	Diarrhea	Nipple discharge	Nursing?
Sinus problems	Heartburn	Endocrine	
Sore throat (frequent)	Hemorrhoids	Excessive weight gain	
Swallowing difficulty	Nausea	Excessive weight loss	

1. Have you been treated by a chiropractor in the past? Yes / No
2. Did you have a good experience? Please explain to us what you liked or what you did not like:

3. When was your last adjustment:

4. How long were you under care?

TREATMENT: What type of treatment are you looking for?

- I am looking for the most minimal amount of care to “patch up the symptoms” of my problem.
- I am looking to resolve my symptoms and then go on to “fix the cause” of my problem.
- I am looking to take care of my problem and then go on to “achieve optimal health and wellness.”

Habits: Please mark the box in the area of the spectrum where you would find yourself most days.

Drink > 5 glasses water/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drink coffee/ soda/ alcohol
Eat whole foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eat refined foods, fried foods, hydrogenated fat, same foods
Fresh air in home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unclean air ducts/ mold
Exercise/ Walk up stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No structured exercise in week
Stretch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No stretching / inflexible
Wear supportive shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wear heels or non-supportive shoes
Feel rested / sleep on back/side w/ Cervical Pillow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Un-rested, sleep on stomach
Do what you enjoy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do what you have to
Quality time w/ family, friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work all the time
Positive mental attitude/purpose in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Negative, aimless thoughts
Ask yourself difficult questions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid internal/ external conflict
Laugh at self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Take yourself very serious

I certify that I have answered the above information to the best of my knowledge.

Patient Signature _____ Date _____

