First Name_____ Last Name_____ Date_____
Address _____City_____ State_____ Zip _____
Phone # _____ Driver Lic. # _____
Email Address _____
** New Federal regulations require us to email you your health information. By providing my email address, I authorize my doctor to contract me regarding my health records.
Gender ☐ Male ☐ Female Date of Birth_____ Age_____ SS# _____
Employment Status: ☐ Employed ☐ Student ☐ Retired ☐ Unemployed **Occupation** _____
Employer _____ Number of Children_____
Marital Status: ☐ S ☐ M ☐ D ☐ W Spouse's Name _____
Spouse's Occupation _____ Spouse's Employer _____
Race: (Check one) ☐ White ☐ Black/African American ☐ Hispanic ☐ Other _____ Multi-Racial: ☐ Yes ☐ No
Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former Smoker ☐ Never been a smoker ☐ Chew tobacco ☐ Packs/day <1, 1 , 2 , 3 , 4+
What is your chief complaint? _____
How were you refereed to our office? _____

List/Check all complaints/conditions you have had or currently have:

General: None☐
☐ Allergy_____
☐ Headaches/Migraines
☐ Loss of Sleep
☐ Anxiety/Panic/Depression
☐ Loss of Energy
☐ Cancer Type:_____
☐ Other_____

Musculoskeletal & Neurological: None☐
☐ Neck Pain/Stiffness
☐ Back Pain/Stiffness
☐ Bulging/Herniated Discs/Degeneration
☐ Arthritis/Join Inflammation
☐ MS/RA/SLE (Autoimmune)
☐ Fibromyalgia
☐ Other _____

Genito-Urinary: None☐
☐ Kidney Infections/Stones
☐ Frequent Urination
☐ Other_____

Gastrointestinal: None☐
☐ Reflux/Indigestion
☐ Constipation
☐ Irritable Bowel
☐ Other_____

Cardiovascular/Respiratory: None☐
☐ **Do you have a pacemaker? YES NO**
☐ High Cholesterol
☐ Blood Pressure HIGH/LOW
☐ Muscle Cramps
☐ Shortness of Breath
☐ Other_____

Women-OB/GYN: None☐
☐ **Are you pregnant? YES NO**
☐ PMS/Painful Menstrual Cycle
☐ Hot Flashes/Menopausal Issues
☐ Irregular Menses
☐ Other_____

Hormonal, Blood & Skin: None☐
☐ Diabetes _____Type 1 _____Type 2
☐ Thyroid Issues
☐ HIV/AIDS
☐ Hepatitis Type:_____
☐ Easy Bruising
☐ Skin Problems:_____
☐ Other_____

Ears/Eyes/Nose/Throat: None☐
☐ Cataracts/Macular Degeneration
☐ Ringing In Ears
☐ Sinus Infections/Blockages
☐ Other_____

Social History: None☐
☐ Alcohol NOT consumed
☐ Alcohol/day <1, 1 , 2 , 3 , 4+
☐ Caffeine NOT consumed
☐ Caffeine / Day <1, 1 , 2 , 3 , 4+
☐ Exercise__freq___occas___none
☐ _____

Family History: None☐
*Please list family member with condition on line
☐ Arthritis_____
☐ Cancer_____
☐ Diabetes_____
☐ Heart Problems_____
☐ Other:_____

List all surgeries:
_____
_____
_____
_____
_____
_____
_____

List all recreational activities:
_____
_____

List all current medications and dosages: (Prescription/OTC/Nutritional)_____
_____
List all past illnesses or accidents: _____
Have you had any X-rays/MRI/CAT Scan within the last year? (If yes, what facility?) _____
_____
List all physicians seen for this condition: _____
What are your goals for care in our office?
☐ I Just want some relief of my immediate pain.
☐ I would like to correct the underlying problem so it doesn't return.
☐ I am Interested in being healthiest and learning to stay that way

I clearly understand and agree that all services rendered to me are charged to me and that I am personally responsible for payment. If filing a claim through any third party and the claim or treatment is not allowed. I agree that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fee for professional service rendered to me will be immediately due and payable.

Patient or Parent/Guardian Signature _____Date _____

Please list your area of complaint & indicate which side of the body the pain is located on:

1._____Right/Left/Both
2._____Right/Left/Both
3._____Right/Left/Both
4._____Right/Left/Both
5. _____Right/Left/Both
6._____Right/Left/Both

How long have you had this condition? _____

What caused your painful Symptoms to begin? _____

Is this condition (Only Check One) ☐ Better or ☐ Worse (In the) ☐ morning ☐ Mid-day ☐ end of the day ☐ night

Does the pain travel anywhere? ☐ Yes ☐ No If yes, Where? _____

DO NOT WRITE BELOW - FOR OFFICE USE ONLY:

NOTES:

_____

_____

Symptoms that explain how the pain feels:

_____Aching	_____Heavy	_____ "Pops"	_____Stinging
_____Annoying	_____Jabbing	_____Pressure	_____Squeezing
_____Burning	_____ "Just Hurts"	_____Pulling	_____Tender
_____Buzzing	_____ "Kink"	_____Radiating	_____Tense
_____ "Catches"	_____Knots	_____Sharp	_____Throbbing
_____Cramping	_____Nagging	_____Sharp with movement	_____Tightness
_____Deep	_____Nasty	_____Shooting	_____Tingling
_____Dull	_____Nauseating	_____Shoots to front	_____Tiredness
_____Electric Shock	_____Numbness	_____Sore	_____ Twinges
_____Grabbing	_____Ouchy	_____Spasm	_____Weakness
_____Grinding	_____Pinching	_____Stabbing	_____
_____Gnawing	_____Pinprick	_____Stiffness	_____

Factors that increase symptoms:

_____Activity	_____Getting up from sitting	_____Making the bed	_____Stooping
_____Baking	_____Golfing	_____Movement	_____Strain w/bowel movement
_____Bending	_____Grocery shopping	_____Raising the arm	_____Stress
_____Carrying	_____Household chores	_____Raking leaves	_____Stretching
_____Changing positions	_____Laughing	_____Reaching	_____Talking on the phone
_____Child or pet care	_____Lifting	_____Reading	_____Touching the area
_____Chewing	_____Lights	_____Repetitive motions	_____Traveling
_____Cleaning	_____Looking down	_____ Rotating head to left	_____Twisting
_____Computer use	_____Looking over shoulder	_____Rotating head to right	_____Vacuuming
_____Cooking	_____Looking up	_____Running	_____Vibration
_____Coughing	_____Lying down	_____Shoveling snow	_____Walking
_____Driving	_____Lying on side	_____Sitting in poor posture	_____Washing dishes
_____Exercise	_____Mopping	_____Squeezing	_____Working
_____Getting in/out car	_____Pulling	_____Squatting	_____Yardwork
_____Getting out of bed	_____Pushing	_____Stair stepping	_____
_____Getting up from laying	_____Quick movement	_____Standing	_____

Factors that Relieve symptoms:

_____Chiro adjustment	_____Knees bent up	_____Nothing	_____Stretching
_____Bending	_____Leaning for support	_____ Pain relief gel	_____Turning on other side
_____Bending forward	_____Lying down	_____Physical therapy	_____Walking
_____Elevating leg	_____Massage	_____Propping feet up	_____
_____Exercise	_____Medication (OTC)	_____Rest	_____
_____Heat packs	_____Medication(prescription)	_____Standing	_____
_____Hot shower/bath	_____Movement	_____Sitting	_____
_____Ice/cold packs	_____No movement	_____Sitting with pillows	_____