

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ SS# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ DL# \_\_\_\_\_  
 OCCUPATION \_\_\_\_\_ SPOUSE \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_ SPOUSE'S OCCUPATION \_\_\_\_\_  
 PHONE \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_ # OF CHILDREN \_\_\_\_\_ EMAIL \_\_\_\_\_  
 Contact in case of emergency \_\_\_\_\_ REFERRED BY \_\_\_\_\_

**MY GOAL FOR CONSULTING WITH THE DOCTOR:**  Temporary Relief  Lasting Correction  Let Doctor Recommend The Best Type Of Care For You

Major Complaint: (Worst Pain) \_\_\_\_\_ Timing:  0-25%  26-50%  51-75%  76-100% of the time

How Serious Do You Think Your Problem Is? \_\_\_\_\_

What caused it? How did it start? (Gradual / Injury) \_\_\_\_\_

When was the first time you became aware of this problem? How long have you had it)? \_\_\_\_\_

Constant  Comes and Goes \_\_\_\_\_ Is it progressively getting worse?  Yes  No

Medications you are on now: \_\_\_\_\_

What makes it better? \_\_\_\_\_ Worse? \_\_\_\_\_

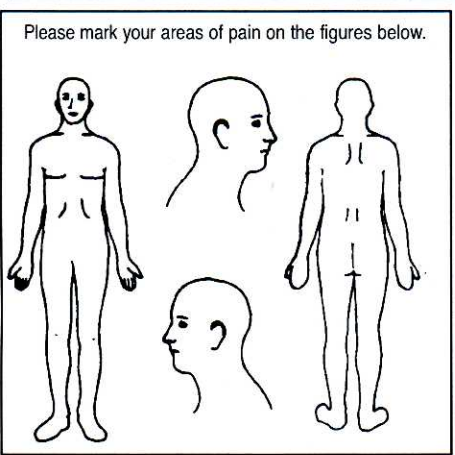
Describe the problem when it is at its worst. \_\_\_\_\_

How has this problem affected your life?

1. Difficulty In Performing Basic Activities of Daily Living -  Bathing/showering  Shaving  Dressing
2. Daily duties: Difficulty In Performing -  Cleaning  Washing Dishes  Sweeping Mopping
3. Hobbies: Slowing Or Prevention Of Certain Hobbies \_\_\_\_\_
4. Work:  I Just Get Through = Slower Production Due To Pain  Cannot Work At All
5. Family/Social:  Not As Easy Going  Grumpy Feeling Due To Pain  Depression/Angry Due To Pain

What activity would you like to be able to do again that is difficult or that you cannot do now? \_\_\_\_\_

This was a new/old illness. Treatment? \_\_\_\_\_ Doctors \_\_\_\_\_



Please mark your areas of pain on the figures below.

Mark any other symptoms you have had in past 6 months. Rate the severity of your problem. 1-10 (1 - slight problem, 10- severe) pain. Leave blank if doesn't apply.

**Musculoskeletal**

- Headaches
- Neck Problems
- Shoulder Problems
- Arm Problems
- Numb - Arms/Fingers
- Pain Between Shoulders
- Low Back Problems
- Leg Problems
- Numbness - Legs/Toes
- Loss of Feeling
- Stiff Joints
- Painful Joints
- Sore Muscles
- Muscle Cramps
- Broken Bones

**Neurological**

- Weak Muscles
- Dizziness
- Memory Problems
- Mental / Emotional**
- Extreme Worry
- Depression
- Anxiety
- Insomnia
- Vision Problems
- Ear Infection
- Ear Pain/Noises
- Hearing Loss R. L.
- Frequent Colds / Flu
- Fatigue / Low Energy

**Past History**

- Allergies/medications \_\_\_\_\_
- Sinus / Hay Fever
- Asthma / Bronchitis
- Heart Problems
- Angina, MI, CAD, COPD, CHF
- Blood Pressure High / Low
- Kidney Problems
- Indigestion or Nausea
- Ulcers
- Skin Problems
- Constipation
- Diarrhea / Constipation
- Diabetes / Blood Sugar Problem
- Menstrual Cramps / PMS

**ADL** \_\_\_\_\_ Restricts Daily Activities \_\_\_\_\_ Restricts Regular Exercise \_\_\_\_\_ Difficulty Walking/Standing Sitting Household duties \_\_\_\_\_

Surgeries/Hospitalizations \_\_\_\_\_

Have you had an MRI/CT Scan? \_\_\_\_\_ Dates \_\_\_\_\_

Previous Chiropractic Care \_\_\_\_\_

Date of last adjustment \_\_\_\_\_

• Female: Are you pregnant at this time?  Yes  No Due Date \_\_\_\_\_

Do you have a pacemaker?  Yes  No

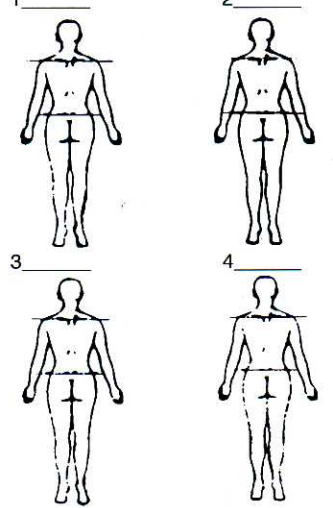
**TRAUMA FROM BIRTH TO PRESENT PLEASE LIST BY DATE/DESCRIBE**

- 1) Injuries or Falls \_\_\_\_\_
  - 2) Broken Bones \_\_\_\_\_
  - 3) Car/Bike Accidents \_\_\_\_\_
- Do you have any metal in your body?  Yes  No
- If yes, where? \_\_\_\_\_
- Sign & Date: \_\_\_\_\_

**(FOR DOCTORS USE ONLY)**

	Date	1	2	3	4
<b>CERVICAL</b>	Norm				
Flexion	50				
Extension	60				
Lat. R. Flex	45				
Lat. L. Flex	45				
Rotation Right	80				
Rotation Left	80				
<b>LUMBAR</b>	Norm				
Flexion	60				
Extension	25				
Lat. R. Flex	25				
Lat. L. Flex	25				
Rotation Right	30				
Rotation Left	30				

	1	2	3	4
CS	LR	LR	LR	LR
CT				
CR				
TS				
TT				
TR				
PS				
PT				
PR				
Dyananometer				



Comments \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_