

Name: _____
Email: _____ Date of Birth: _____ Height: _____ Weight: _____

What is the primary reason/problem/condition you have come in for chiropractic treatment?

Have you had similar problems before? No Yes If yes, When? _____

Have you had Chiropractic care in the past? No Yes

Are there any other issues/problems you wish the doctor to know about: _____

Have you had any recent falls, traumas or other accidents? No Yes Describe: _____

What is the initial date of injury or onset of this condition? _____ Are you off from work? No Yes

Rate your restriction of performing activities of daily living on a scale from 0 to 10

(no restriction) 0 1 2 3 4 5 6 7 8 9 10 (severe restriction)

Over the past 2 weeks what is your average level of pain on a scale from 0 to 10?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain) What level is your pain today? ____/10

Is your pain or discomfort? (Mark with a ✓) continuous off and on getting worse sharp or stabbing

Do you perform moderately intense exercise 3 time per week? No Yes

Is your MD currently co-treating your condition? No Yes If yes, who: _____

What recent diagnostic studies (x-ray, MRI, CT, blood work) have you had? _____

Taken where? _____

List symptoms you have had recently: Headache Numbness or tingling in arms/hand or legs/feet Fever

[] Difficulty sleeping Other: _____

List your Current Medications: _____

Medication Allergies: _____

List your Allergies: None Seasonal/Pollen Food Animals X-Ray Dye Other: _____

List any Surgeries: None Neck Back Hip Knee Shoulder Brain Other: _____

List your Medical Conditions: None High Blood Pressure Diabetes Stroke Cancer

Other: _____

List your Family Medical History (Example: maternal grandmother - high blood pressure, Father – heart attack)

Do you smoke or use tobacco products? No Yes Former Smoker? No Yes

Do you have currently have significant problems with depression or anxiety? No Yes

Do you drink alcohol? No Yes – How many per day? _____

Do you drink caffeine? No Yes – How many per day? _____

Do you exercise? No Yes – What forms and how often? _____

Patient Signature: _____ Date: _____