Name ____________________ Date ____________ Occupation ______________

Age ______ Birthdate __________ Sex: M F Previous Chiropractor, if any: ______________

Present Concern(s): What bothers you most? (concern #1) ______________

Next most? (concern #2) ______________

Other Concerns: ______________

When did the problem first begin? (concern #1) ______________ (concern #2) ______________

How frequent are the symptoms present? (#1) ☐ Constant (76-100%) ☐ Occasional (26-50%) ☐ Frequent (51-75%) ☐ Intermittent (25% or less)

How long does the pain last? (#1) ☐ A few minutes ☐ A few hours ☐ A few days ☐ Comes and goes

Have you ever experienced these symptoms before? (#1) ☐ Yes ☐ No If yes, approximately how many times? _____

When does the pain occur? (#1) ☐ Upon waking ☐ Daytime ☐ During sleep ☐ Depends on position

How did your problem begin? (#1) ☐ Gradually developed ☐ Immediately after a specific incident ☐ After multiple incidents

Mechanism of Injury (#1): ☐ Fall ☐ Lifting ☐ Sports related ☐ Work related ☐ Auto accident ☐ Other

Please explain: ______________

What have you done to TRY to relieve your symptoms? (#1) ______________

What have you done that WORKS to relieve your symptoms? (#1) ______________

What makes your symptoms worse? (#1) ______________

Does the pain radiate into another body area? (#1) If yes, where? ______________

Is your pain: (#1) ☐ Mild ☐ Moderate ☐ Considerable ☐ Severe

Please circle the number or numbers which reflect the severity of your pain (#1): 0 1 2 3 4 5 6 7 8 9 10

Since your problem began, is it (#1): ☐ Increasing ☐ Decreasing ☐ No change

---

How frequent are the symptoms present? (#2) ☐ Constant (76-100%) ☐ Occasional (26-50%) ☐ Frequent (51-75%) ☐ Intermittent (25% or less)

How long does the pain last? (#2) ☐ A few minutes ☐ A few hours ☐ A few days ☐ Comes and goes

Have you ever experienced these symptoms before? (#2) ☐ Yes ☐ No If yes, approximately how many times? _____

When does the pain occur? (#2) ☐ Upon waking ☐ Daytime ☐ During sleep ☐ Depends on position

Mechanism of Injury (#2): ☐ Fall ☐ Lifting ☐ Sports related ☐ Work related ☐ Auto accident ☐ Other

Please explain: ______________

What have you done to TRY to relieve your symptoms? (#2) ______________

What have you done that WORKS to relieve your symptoms? (#2) ______________

What makes your symptoms worse? (#2) ______________

Does the pain radiate into another body area? (#2) If yes, where? ______________

Is your pain: (#2) ☐ Mild ☐ Moderate ☐ Considerable ☐ Severe

Please circle the number or numbers which reflect the severity of your pain (#2): 0 1 2 3 4 5 6 7 8 9 10

Since your problem began, is it (#2): ☐ Increasing ☐ Decreasing ☐ No change

For #1 AND #2: Do you experience any weakness, pain, numbness, tingling, burning, or other abnormal sensations in your arms, hands, fingers, legs, feet, or toes? ☐ Yes ☐ No

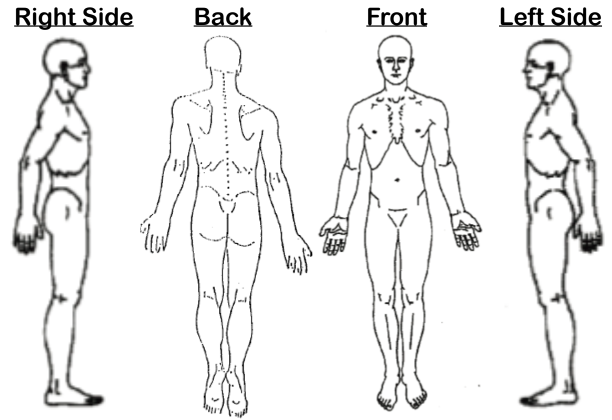
Do you experience any symptoms when coughing, sneezing, laughing or having a bowel movement? ☐ Yes ☐ No

Have you seen any other health care providers for this condition? YES NO

Date	Name	Phone Number

Please mark on the picture, using letters below,
to indicate the type and location of your sensations or symptoms.

(please include all areas of discomfort)



A = Ache S = Stabbing or Sharp

B = Burning D = Dull

N = Numbness X = Tingling

T = Throbbing Z = Other

Thank you for answering the following questions. A complete understanding of your health status will facilitate proper evaluation and treatment of your complaints.

PAST HISTORY

List any previous injuries (slips, falls, auto accidents, sports injuries, broken bones, etc., and give dates.

___

___

Have you had previous neck or back problems? YES NO If so, describe and give dates.

___

___

List any past significant illnesses and give dates:___

___

List any allergies:___

Are you under another doctor's care for any reason? YES NO If so, give name and condition.___

___

List all surgeries and hospitalizations and give dates.

YEAR	PROBLEM	HOSPITAL or CLINIC

Are you taking any medications? (Prescription or Non-prescription) If so, please list name and condition treated.___

___

___

FAMILY HISTORY

Is there a FAMILY history of serious illness? YES NO If yes, please explain:___

___

SOCIAL HISTORY

Have you recently been under a significant amount of personal stress? YES NO If yes, please explain:

___

___

Do you think stress may be contributing to your symptoms? If yes, please explain:___

___

___

Have you ever had any of the following conditions? Please check all that apply:

Past	Now	Condition
☐	☐	Angina
☐	☐	Anemia
☐	☐	Measles
☐	☐	Osteoarthritis
☐	☐	Smallpox
☐	☐	Pleurisy
☐	☐	Stroke
☐	☐	Bursitis
☐	☐	Pneumonia
☐	☐	Epilepsy
☐	☐	Hayfever
☐	☐	Hepatitis: A, B, or C
☐	☐	Bronchitis
☐	☐	Diphtheria
☐	☐	High blood pressure
☐	☐	Emphysema
☐	☐	Chickenpox
☐	☐	Malaria
☐	☐	Diabetes
☐	☐	Mumps
☐	☐	Birth defects
☐	☐	Ringing in ears
☐	☐	Sinus trouble
☐	☐	Thirsty all the time
☐	☐	Cold most of the time
☐	☐	Warm most of the time
☐	☐	Unusually tired
☐	☐	Awaken tired/ exhausted

Past	Now	Condition
☐	☐	Dizziness
☐	☐	Incoordination
☐	☐	Jumpy or nervous
☐	☐	Spinal curvature
☐	☐	Wear bifocals
☐	☐	Neck frequently cracks
☐	☐	Stiff joints upon arising
☐	☐	Tuberculosis
☐	☐	Rheumatoid arthritis
☐	☐	Osteoporosis
☐	☐	Osteopenia
☐	☐	Hypoglycemia
☐	☐	Meningitis
☐	☐	Prostatitis
☐	☐	Encephalitis
☐	☐	Alcoholism
☐	☐	Polio
☐	☐	Ulcer
☐	☐	Eczema
☐	☐	Psoriasis
☐	☐	Asthma
☐	☐	Colitis
☐	☐	Gout
☐	☐	Ankylosing spondylitis
☐	☐	Gallbladder disease
☐	☐	Kidney stones
☐	☐	Hernia
☐	☐	Typhoid fever

Past	Now	Condition
☐	☐	Food cravings
☐	☐	Bruise easily
☐	☐	Shingles/ herpes zoster
☐	☐	Whooping cough
☐	☐	Migraine headaches
☐	☐	Headaches
☐	☐	Tumor or cancer
☐	☐	Heart disease
☐	☐	Heart attack
☐	☐	Diverticulosis
☐	☐	Rheumatic fever
☐	☐	Venereal disease
☐	☐	Bowel condition
☐	☐	Chemical dependency
☐	☐	HIV
☐	☐	Kidney condition
☐	☐	Bladder condition
☐	☐	Urinary problems
☐	☐	Night sweats
☐	☐	Changing mole
☐	☐	Blood in stool
☐	☐	Blood in urine
☐	☐	Thyroid disease
☐	☐	Scarlet fever
☐	☐	Frequent colds
☐	☐	Lupus
☐	☐	Other: please specify

____

Do you now or have you recently had a fever? Yes No

Do you have shortness of breath when NOT exerting yourself? Yes No

Do you have a phlegm producing cough? Yes No If yes, what color is it? ______________________________

Do you have recent hearing changes? Yes No If yes, please explain: ______________________________

Do you have recent visual changes Yes No If yes, please explain: ______________________________

Do you have nausea? Yes No If yes, please explain: ______________________________

Do you have difficulty controlling your bowel or bladder? Yes No If yes, please explain: ______________________________

Do you have stomach upset with certain foods? Yes No If yes, please explain: ______________________________

Do you have indigestion after meals? Yes No If yes, please explain: ______________________________

Do you have a recent change in sexual ability? Yes No If yes, please explain: ______________________________

Have you had a recent unexplainable weight change? (gaining or losing) Yes No If yes, please explain: ______________

<u>Tobacco and Alcohol Use:</u> Has your use of alcohol or other chemicals increased since your symptoms or pain began? Yes No

Do you smoke? No Yes How much?______________ If you have quit, how long has it been since you quit smoking? __________

Past	Now	Feet (please circle choices)
☐	☐	High arches: Right Left
☐	☐	Fallen arches: Right Left
☐	☐	Swollen ankles: Right Left
☐	☐	Use foot / shoe appliance: Right Left
☐	☐	Change of shoes causes / helps relieve pain
☐	☐	Bunions: Right Left
☐	☐	Corns: Right Left
☐	☐	Callouses: Right Left
☐	☐	Plantar warts: Right Left
☐	☐	Plantar fasciitis: Right Left
☐	☐	Heel spurs: Right Left
☐	☐	Wear shoes out on outside: Right Left
☐	☐	Wear shoes out on inside: Right Left
☐	☐	Athlete's foot: Right Left
☐	☐	Ingrown toenails: Right Left
☐	☐	Other? Please describe: ____________________

Have you ever consulted with a podiatrist (foot specialist)?

No Yes For what condition? ____________________________

General Information - for Women Only

__________ Date of last menstrual period (start)

__________ Age menstrual periods stopped

__________ If pregnant, number of months

__________ Number of pregnancies

__________ Number of births

__________ Ages of children

Are you still menstruating regularly? Yes No

General Information - for Everyone

Who is your medical physician? ________________________

Who is your dentist? ________________________________

When did you last have a complete physical examination?

____

Results:_______________________________________

Where are there scars on your body and briefly the cause:

____

____

Do you get enough sleep? Yes No Hours per night:_______

Do you like your mattress? Yes No If no, why not?______

____

Do you like your pillow? Yes No If no,why not?

____

Are you right or left hand dominant? RIGHT LEFT

Do you carry a child on a hip? Yes No

Do you carry a purse, briefcase, computer bag, backpack, etc. over one shoulder? Yes No RIGHT LEFT

Please list the dietary, nutritional, and herbal supplements you are taking: ________________________

____

____

Do you consider your diet to be:

excellent good fair poor

Why? ____

How many servings per day / week do you consume of the following:

	1 to 2	3 to 4	5 to 6	Day	Week
Fruit	☐	☐	☐	☐	☐
Vegetables	☐	☐	☐	☐	☐
Whole grains	☐	☐	☐	☐	☐
Refined grains	☐	☐	☐	☐	☐
Sweets	☐	☐	☐	☐	☐
Pop	☐	☐	☐	☐	☐
Coffee	☐	☐	☐	☐	☐
Tea	☐	☐	☐	☐	☐
Milk	☐	☐	☐	☐	☐
Water	☐	☐	☐	☐	☐
Red meat	☐	☐	☐	☐	☐
White meat	☐	☐	☐	☐	☐
Fish	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐
Other protein	☐	☐	☐	☐	☐
Dairy	☐	☐	☐	☐	☐

On a scale of 1 to 10, how much commitment are you willing to give to improve your health?

1 2 3 4 5 6 7 8 9 10

Work and/ or Daily Task Information

Type of work you do:____

Employer:____

Please give a brief description of you daily duties:____

____

Usual Job Tasks

Please circle the approximate percent of time you spend in each of the following activities.

Activity					
Standing	0 %	1-25%	26-50%	51-75%	76-100%
Sitting	0 %	1-25%	26-50%	51-75%	76-100%
Walking	0 %	1-25%	26-50%	51-75%	76-100%
Bending	0 %	1-25%	26-50%	51-75%	76-100%
Lifting	0 %	1-25%	26-50%	51-75%	76-100%
Typing	0 %	1-25%	26-50%	51-75%	76-100%
Computer	0 %	1-25%	26-50%	51-75%	76-100%
Telephone	0 %	1-25%	26-50%	51-75%	76-100%
Driving	0 %	1-25%	26-50%	51-75%	76-100%

Please circle your answers to the following questions:

Question			
How satisfied are you with your job?	Not at all	Somewhat	Very
How rewarding is your job?	Not at all	Somewhat	Very
How stressful is your job?	Not at all	Somewhat	Very
How noisy is your job?	Not at all	Somewhat	Very

Do you work with others who can assist you to perform heavy work? Yes No

Are there “light duty” tasks available for you if necessary? Yes No

Is your present complaint related to a past or present job injury? Yes Past Present No

Do you have any special postures or physical demands for work or for recreation? Yes No

What recreational activities, hobbies, or active interests are you involved in? ____

____

____

____

What do you do for exercise and what is the frequency?____

____

____

____

Comments:____

____