

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 check 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 check 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

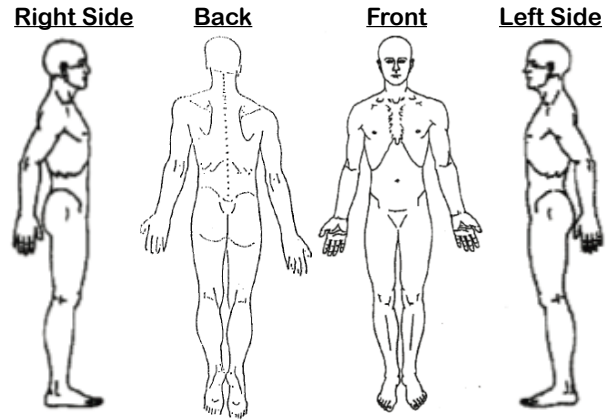
Do you experience any symptoms when coughing, sneezing, laughing or having a bowel movement? Yes No

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
- B = Burning
- N = Numbness
- T = Throbbing
- S = Stabbing or Sharp
- D = Dull
- X = Tingling
- 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
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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		Past	Now		Past	Now	
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Food cravings
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Jumpy or nervous	<input type="checkbox"/>	<input type="checkbox"/>	Shingles/ herpes zoster
<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>	Whooping cough
<input type="checkbox"/>	<input type="checkbox"/>	Smallpox	<input type="checkbox"/>	<input type="checkbox"/>	Wear bifocals	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches
<input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	Neck frequently cracks	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Stiff joints upon arising	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or cancer
<input type="checkbox"/>	<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulosis
<input type="checkbox"/>	<input type="checkbox"/>	Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: A, B, or C	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	Bowel condition
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	Prostatitis	<input type="checkbox"/>	<input type="checkbox"/>	Chemical dependency
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	HIV
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Kidney condition
<input type="checkbox"/>	<input type="checkbox"/>	Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	Bladder condition
<input type="checkbox"/>	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Urinary problems
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Changing mole
<input type="checkbox"/>	<input type="checkbox"/>	Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	Thirsty all the time	<input type="checkbox"/>	<input type="checkbox"/>	Ankylosing spondylitis	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	Cold most of the time	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds
<input type="checkbox"/>	<input type="checkbox"/>	Warm most of the time	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Unusually tired	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Other: please specify
<input type="checkbox"/>	<input type="checkbox"/>	Awaken tired/ exhausted	<input type="checkbox"/>	<input type="checkbox"/>	Typhoid fever			

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: _____

Tobacco and Alcohol Use: 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: _____

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? _____

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? _____

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

	1 to 2	3 to 4	5 to 6	Day	Week
Fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole grains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refined grains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other protein	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

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:

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: _____
