

PERSONAL INFORMATION

NAME: _____ BIRTH DATE: _____ AGE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: (_____) _____ -- _____ WORK PHONE: (_____) _____ -- _____

HOME PHONE: (_____) _____ -- _____ E-MAIL: _____

SS #: _____ -- _____ -- _____ GENDER: M F REFERRED BY: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SPOUSE/PARTNER NAME: _____

OCCUPATION: _____ EMPLOYER: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

EMERGENCY CONTACT INFORMATION

CONTACT NAME: _____ CONTACT PHONE: (_____) _____ -- _____

RELATIONSHIP: _____

IS CONDITION: JOB RELATED AUTO ACCIDENT HOME INJURY FALL OTHER: _____

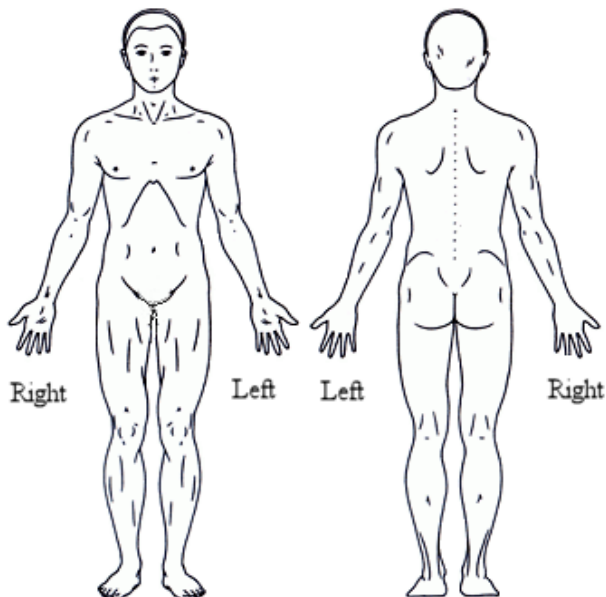
CURRENT HEALTH CONDITION

SPECIFIC PURPOSE OF THIS APPOINTMENT: _____

IF YOU HAVE PAIN, DOES IT TRAVEL OR RADIATE ANYWHERE ELSE IN YOUR BODY? Y N

IF YES, WHERE DOES IT TRAVEL / RADIATE TO? _____

**PLEASE MARK YOUR PROBLEM AREAS
ON THE DIAGRAM BELOW**



HOW INTENSE ARE YOUR SYMPTOMS?

MILD MODERATE SEVERE

HOW WOULD YOU RATE YOUR DISCOMFORT AT ITS WORST?

0 1 2 3 4 5 6 7 8 9 10

NO
PAIN

WORST
PAIN
EVER

THE PAIN / DISCOMFORT IS:

CONSTANT COMES & GOES

WHEN DID THIS PROBLEM BEGIN?: _____ HOW DID IT START? GRADUALLY SUDDENLY

HAS THIS PROBLEM OCCURRED BEFORE? Y N IF YES, WHEN? _____

IF YES, WHAT DID YOU DO AND WHAT WAS THE OUTCOME? _____

DID ANYTHING CONTRIBUTE TO THE ONSET OF YOUR PROBLEM? _____

DOES THIS CONDITION NEGATIVELY AFFECT YOUR:

- | | | | | |
|--------------------------------------|-----------------------------------|------------------------------------|--|--|
| <input type="checkbox"/> WORK | <input type="checkbox"/> STANDING | <input type="checkbox"/> SELF-CARE | <input type="checkbox"/> EXERCISE / SPORTS | <input type="checkbox"/> MOOD |
| <input type="checkbox"/> SCHOOL | <input type="checkbox"/> SITTING | <input type="checkbox"/> SLEEPING | <input type="checkbox"/> RELATIONSHIPS | <input type="checkbox"/> SEXUAL FUNCTION |
| <input type="checkbox"/> SOCIAL LIFE | <input type="checkbox"/> WALKING | <input type="checkbox"/> LIFTING | <input type="checkbox"/> CONCENTRATION | <input type="checkbox"/> OTHER: _____ |

HOW OFTEN DO YOU EXPERIENCE YOUR PROBLEM (E.G. DAILY, ONCE PER WEEK, ETC.)? _____

DOES ANYTHING MAKE YOUR PROBLEM WORSE (E.G. SITTING, STANDING, BENDING, ETC.)? _____

DOES ANYTHING MAKE YOUR PROBLEM BETTER? _____

HAVE YOU HAD ANY CHANGES IN BODILY FUNCTIONS (BOWEL / BLADDER CONTROL, BREATHING, ETC.)? Y N

IF YES, PLEASE EXPLAIN: _____

ARE YOU CURRENTLY EXPERIENCING ANY MUSCLE WEAKNESS OR NUMBNESS ON ONE SIDE OF YOUR BODY, DIZZINESS, NAUSEA, HEADACHES, DIFFICULTY SPEAKING, DIFFICULTY SWALLOWING OR VISION PROBLEMS? Y N

IF YES, PLEASE CIRCLE SYMPTOMS ABOVE AND EXPLAIN: _____

HAVE YOU SEEN ANY OTHER HEALTHCARE PROFESSIONALS FOR THIS CONDITION? ? Y N

IF YES, WHO AND WHEN? _____

PLEASE LIST ANY OTHER PERSISTENT MEDICAL CONDITIONS YOU SUFFER FROM: _____

PREVIOUS CHIROPRACTIC CARE HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? Y N

IF YES, FOR WHAT PROBLEM: _____ DATE OF LAST VISIT: _____

DOCTOR'S NAME: _____ HOW LONG WERE YOU UNDER CARE? _____

HOW WAS YOUR EXPERIENCE? _____

NAME: _____

DATE: _____

PLEASE PLACE AN [X] NEXT TO ANY CONDITIONS YOU ARE CURRENTLY SUFFERING FROM AND A [•] NEXT TO ANY CONDITIONS YOU HAVE HAD IN THE PAST.

GENERAL

- ___ Headaches
- ___ Migraine Headaches
- ___ Allergies
- ___ Sleep Difficulties
- ___ Jaw Problems
- ___ Bruise Easily
- ___ Fatigue
- ___ Depression
- ___ Anxiety
- ___ Mental / Emotional Disorder
- ___ Eating Disorder
- ___ Learning Disability
- ___ Attention Deficit
- ___ Cancer
- ___ Diabetes
- ___ Osteoporosis

MUSCLES & JOINTS

- ___ Neck Pain
- ___ Pain Between Shoulders
- ___ Low Back Pain
- ___ Joint Pain / Stiffness
- ___ Arthritis
- ___ Muscle Tightness
- ___ Difficulties Walking
- ___ Carpal Tunnel

NERVOUS SYSTEM

- ___ Numbness / Tingling
- ___ Weakness
- ___ Dizziness
- ___ Paralysis
- ___ Fainting
- ___ Ringing In Ears
- ___ Convulsions/ Epilepsy
- ___ Loss of Balance
- ___ Seizures

GASTROINTESTINAL

- ___ Belching / Gas
- ___ Constipation
- ___ Diarrhea
- ___ Excessive Hunger / Thirst
- ___ Poor Appetite
- ___ Abdominal Pains / Cramps
- ___ Persistent Nausea
- ___ Gall Bladder Problems
- ___ Hemorrhoids
- ___ Nausea
- ___ Vomiting
- ___ Heartburn / Reflux
- ___ Black / Bloody Stools
- ___ Loose Stools
- ___ Gall Bladder Problems
- ___ Colitis
- ___ Digestive Problems
- ___ Loss of Bowel Control

CARDIOVASCULAR

- ___ Chest Pain
- ___ Shortness of Breath
- ___ Blood Pressure Problems
- ___ Heart Problems
- ___ Heart Attack
- ___ Stroke / TIA
- ___ Irregular Heartbeat
- ___ Swollen Ankles
- ___ Bleeding Problems

RESPIRATORY

- ___ Lung Problems
- ___ Asthma
- ___ Difficulty Breathing
- ___ Cough
- ___ Spitting Blood

GENITOURINARY

- ___ Frequent Urination
- ___ Lack of Bladder Control
- ___ Kidney Problems
- ___ Painful Urination
- ___ Discolored Urine
- ___ Prostate problems

MALE / FEMALE

- ___ Menstrual Irregularity
- ___ Menstrual Cramping
- ___ Vaginal Pain / Infection
- ___ Breast pain / Lumps
- ___ Sexual Dysfunction

FEMALE ONLY

When was your last period? _____

Are you pregnant?

- YES NO NOT SURE

I HEREBY CERTIFY THAT ALL ANSWERS AND INFORMATION PROVIDED ON THESE FORMS IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY HEALTH.

PATIENT SIGNATURE

PRINTED NAME

DATE

PATIENT SPECIFIC FUNCTIONAL SCALE

WE WANT TO KNOW WHAT SORTS OF ACTIVITIES IN YOUR LIFE YOU ARE UNABLE TO PERFORM OR ARE HAVING THE MOST DIFFICULTY WITH AS A RESULT OF YOUR PROBLEM.

INSTRUCTIONS

- PLEASE LIST UP TO 3 ACTIVITIES BELOW THAT YOU ARE CURRENTLY UNABLE TO PERFORM OR ARE HAVING THE MOST DIFFICULTY WITH AS A RESULT OF YOUR PROBLEM.
- PLEASE THEN RATE YOUR CURRENT ABILITY TO PERFORM THOSE ACTIVITIES BY CIRCLING THE NUMBER THAT BEST REPRESENTS YOUR ABILITY TO ENGAGE IN THAT ACTIVITY.

ACTIVITY # 1: _____

0 1 2 3 4 5 6 7 8 9 10

UNABLE TO PERFORM ACTIVITY ABLE TO PERFORM ACTIVITY AT SAME LEVEL AS BEFORE PROBLEM

ACTIVITY # 2: _____

0 1 2 3 4 5 6 7 8 9 10

UNABLE TO PERFORM ACTIVITY ABLE TO PERFORM ACTIVITY AT SAME LEVEL AS BEFORE PROBLEM

ACTIVITY # 3: _____

0 1 2 3 4 5 6 7 8 9 10

UNABLE TO PERFORM ACTIVITY ABLE TO PERFORM ACTIVITY AT SAME LEVEL AS BEFORE PROBLEM

PATIENT SIGNATURE

PRINTED NAME

DATE