Acct#_____ F/C_____

Describe your symptoms_____

_____

_____

When did your symptoms start? Month _____ Day _____ Year _____

Have you ever had this condition prior to the onset date? ☐ No ☐ Yes If yes, when? _____

What *event/activity/accident* started these symptoms? _____

_____

_____

Since the day your symptoms started; condition is getting (*circle one*): Better Worse Same
Symptoms are (*circle one*) Constant Frequent Occasional Intermittent
Pain is (*circle all that apply*) Numb Sharp Achy Stabbing Electric-like burning Tingling
Does the pain radiate down your arm? ☐ No ☐ Yes If yes: Right Left Comment_____
Does the pain radiate down your leg? ☐ No ☐ Yes If yes: Right Left Comment _____
On a scale of 1 – 10 where do you rate your pain?

Mild 1 2 3 4 5 6 7 8 9 10 Severe

What other tests have you had for this condition? ☐ MRI ☐ CT Scan ☐ X-rays ☐ Other:_____
Who have you seen for this condition? _____
Have you had Physical Therapy for this condition? ☐ No ☐ Yes
Have you had Injections for this condition? ☐ No ☐ Yes
Have you ever had Spinal Surgery? ☐ No ☐ Yes
If yes; explain_____

_____

Have you ever had any accidents, falls, auto accidents, etc. that could have contributed to your current condition? _____

_____

Do you have any hobbies that strain your spine? (*please circle*) Golf Bowling Boating Fishing Yard work

Other:_____

Do you have any other spinal related problems? (*please circle*) Low back pain Neck pain Mid back pain Headaches

Migraines Arm pain Leg pain Other: _____

List ***important*** surgeries have you **ever** had to your spine, joints, or bones; or surgeries in the **last year** to any other body part?

_____

_____

Is there any chance you could be pregnant? ☐ Not Applicable ☐ No ☐ Yes; *date of last period*_____

Have you ever been to a Chiropractor before? ☐ No ☐ Yes

If yes: Clinic/Dr. Name_____ Location _____ Last visit date _____

Reason_____

Acct#_____ F/C_____

**Social History**

Caffeine: ☐ No ☐ Yes If yes, how often? ( ) occasionally ( ) often
Alcohol: ☐ No ☐ Yes If yes, how often? ( ) occasionally ( ) often
Exercise: ☐ No ☐ Yes If yes, how often? ( ) occasionally ( ) often

**Family History** - Parents or siblings only:

☐ Arthritis ☐ Cancer ☐ Cholesterol
☐ Diabetes ☐ Heart problems ☐ High blood pressure
☐ Psychiatric ☐ Stroke ☐ Thyroid

**Activities of Daily Living**

*Please circle* an option that best describes your ability to perform the each of the following activities of daily living.

1) Walking: can walk without pain can walk ½ mile without pain can walk 50 ft without pain unable to walk without pain

2) Driving: can drive without pain can drive 50 mins without pain can drive 10 mins without pain unable to drive without pain

3) Sitting: can sit without pain can sit for 6 hrs without pain can sit for 3 hrs without pain unable to sit without pain

4) Sit to Stand can get up from chair without pain or assistance can get up from chair but with increased pain
unable to get out of chair without pain or assistance

5) Lying: can lay without pain can lay for 60 mins without pain can lay for 30 mins without pain unable to lay without pain

6) Sleeping: able to sleep without pain mildly disturbed (loss of 1-2 hrs) severely disturbed (loss of 3-5 hrs) completely disturbed

7) Housework: can do 90 mins of housework without increased pain can do 60 mins of housework without increased pain
*(heavy)* can do 30 mins of housework without increased pain unable to do housework without increased pain

8) Carrying: can carry heavy objects without pain can manage light weight without pain
can manage medium weight without pain unable to carry anything

9) Headaches: having no headaches having 1 headache per week having 3 headaches per week
having 6 headaches per week having constant headaches

Acct#_____ F/C_____

Have you had a fever or chills during the past week? ☐ No ☐ Yes

**Please use the chart below to inform us of any other medical conditions we should know about.**

***Review of Systems:*** Have you had trouble with any of the following?

| **Cardiovascular:** | ☐ No | |
|---|---|---|
| | Past | Present |
| Poor Circulation | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Aortic Aneurism | ☐ | ☐ |
| Heart Disease | ☐ | ☐ |
| Heart Attack | ☐ | ☐ |
| Chest Pain | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ |
| **Pace Maker** | ☐ | ☐ |
| Jaw Pain | ☐ | ☐ |
| Irregular Heartbeat | ☐ | ☐ |
| Swelling of Legs | ☐ | ☐ |

| **Genitourinary:** | ☐ No | |
|---|---|---|
| | Past | Present |
| Kidney Disease | ☐ | ☐ |
| Lower Side Pain | ☐ | ☐ |
| Burning Urination | ☐ | ☐ |
| Frequent Urination | ☐ | ☐ |
| Blood in Urine | ☐ | ☐ |
| Kidney Stone | ☐ | ☐ |
| Prostrate Problems | ☐ | ☐ |

| **Hematologic/Lymphatic:** | ☐ No | |
|---|---|---|
| | Past | Present |
| Hepatitis | ☐ | ☐ |
| Blood Clots | ☐ | ☐ |
| Cancer** | ☐ | ☐ |
| Easy Bruising | ☐ | ☐ |
| Easy Bleeding | ☐ | ☐ |
| Fevers/Chills/Sweats | ☐ | ☐ |

**Location of Cancer_____

| **Endocrine:** | ☐ No | |
|---|---|---|
| | Past | Present |
| Thyroid Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Hair Loss | ☐ | ☐ |
| Menopausal | ☐ | ☐ |
| Menstrual Problems | ☐ | ☐ |

| **Psychiatric:** | ☐ No | |
|---|---|---|
| | Past | Present |
| Depression | ☐ | ☐ |
| Anxiety Disorder | ☐ | ☐ |
| Unusual Stress | ☐ | ☐ |

| **Respiratory:** | ☐ No | |
|---|---|---|
| | Past | Present |
| Asthma | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Cold/Flu | ☐ | ☐ |
| Cough/Wheezing | ☐ | ☐ |

| **Ears/Nose/Throat:** | ☐ No | |
|---|---|---|
| | Past | Present |
| Dizziness | ☐ | ☐ |
| Hearing Loss | ☐ | ☐ |
| Sinus Problems | ☐ | ☐ |
| Nosebleed | ☐ | ☐ |
| Sore Throat | ☐ | ☐ |
| Difficulty Swallowing | ☐ | ☐ |
| Bleeding Gums | ☐ | ☐ |

| **Eyes:** | ☐ No | |
|---|---|---|
| | Past | Present |
| Glaucoma | ☐ | ☐ |
| Double Vision | ☐ | ☐ |
| Blurred Vision | ☐ | ☐ |

| **Neurologic:** | ☐ No | |
|---|---|---|
| | Past | Present |
| Stroke | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Head Injury | ☐ | ☐ |
| Brain Aneurysm | ☐ | ☐ |
| Numbness | ☐ | ☐ |
| Severe Headaches | ☐ | ☐ |
| Pinched Nerves | ☐ | ☐ |
| Parkinson's | ☐ | ☐ |
| Carpal Tunnel | ☐ | ☐ |
| Spinning/Balance | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Fainting | ☐ | ☐ |

| **Constitutional:** | ☐ No | |
|---|---|---|
| | Past | Present |
| Weight Loss/Gain | ☐ | ☐ |
| Energy Level Problem | ☐ | ☐ |
| Difficulty Sleeping | ☐ | ☐ |

| **Allergic/Immunologic:** | ☐ No | |
|---|---|---|
| | Past | Present |
| Hives | ☐ | ☐ |
| Immune Disorder | ☐ | ☐ |
| HIV/AIDS | ☐ | ☐ |
| Allergy Shots | ☐ | ☐ |
| Cortisone Use | ☐ | ☐ |

| **Gastrointestinal:** | ☐ No | |
|---|---|---|
| | Past | Present |
| Gallbladder Problems | ☐ | ☐ |
| Bowel Problems | ☐ | ☐ |
| Constipation | ☐ | ☐ |
| Liver Problems | ☐ | ☐ |
| Ulcers | ☐ | ☐ |
| Diarrhea | ☐ | ☐ |
| Nausea/Vomiting | ☐ | ☐ |
| Bloody Stools | ☐ | ☐ |
| Poor Appetite | ☐ | ☐ |
| Loss of Bowel Control | ☐ | ☐ |
| Loss of Bladder Control | ☐ | ☐ |
| Heartburn/Indigestion | ☐ | ☐ |

| **Integumentary:** | ☐ No | |
|---|---|---|
| | Past | Present |
| Skin Ulcers | ☐ | ☐ |
| Skin Disease | ☐ | ☐ |
| Eczema | ☐ | ☐ |
| Psoriasis | ☐ | ☐ |
| Rashes | ☐ | ☐ |

| **Musculoskeletal:** | ☐ No | |
|---|---|---|
| | Past | Present |
| Gout | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Joint Stiffness | ☐ | ☐ |
| Muscle Weakness | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ |
| Broken Bones | ☐ | ☐ |
| Joints Replaced | ☐ | ☐ |
| Rheumatoid Arthritis | ☐ | ☐ |

**Permanent Disability Rating** _____%

Other Conditions_____

_____