Name:_____ Sex: M F Date:_____

Address:_____ City:_____ State:_____Zip:_____

Phone: (_____)_____ Date of Birth:_____ Age:_____

Referred by:_____

Occupation:_____ Employer:_____

Have you ever been to a Chiropractor before? Yes No If Yes, when?_____

Was there anything you really liked or disliked about a previous chiropractic experience? _____

_____

How would you define treatment success?_____

What do you think is contributing to your problem?_____

What is your confidence level that chiropractic can help?_____

Primary reason for seeking chiropractic care:_____

Other aches and pains you would like addressed:_____

Is your visit due to an auto accident or workers compensation claim? Yes No
If Yes, explain?_____

Chief Complaint

Location of Complaint:_____

When did this start?_____ How long has it been going on?_____

Did anything happen to cause this?_____

Can you describe the pain: dull ache sharp burning deep other:_____

Does this pain travel or shoot to any other part of your body? Where?_____

Do you have any numbness or tingling in your body? Where?_____

Circle the intensity/severity:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain)

Is the pain always there?_____ If it comes and goes, how long does it last?_____

Does anything make it worse?_____

Does anything make it better?_____

Previous interventions, treatments, medications, surgery, or care you've sought out for this complaint?_____

_____

Previous Health History

Have you had any major illnesses? When?_____

_____

Have you recently been hospitalized? When and why?_____

_____

Have you had any serious injuries/broken bones/traumatic accidents? When?_____

_____

Previous Surgeries: Date:

_____ _____

_____ _____

_____ _____

Medications: Reason for taking:

_____ _____

_____ _____

_____ _____

Do you have any allergies?_____

Family Health History

Do you have a family history of cancer? Yes No What kind?_____

Diabetes? Yes No What type?_____

Vascular/Heart Disease? Yes No Who had it?_____

Other family history of health problems: _____

Social and Occupational History

Job description:_____

Work schedule:_____ Highest level of education:_____

Does your primary complaint affect your job or activities of daily living?_____

To what extent?_____

Recreational activities:_____

Do you smoke? Yes No How much?_____

Do you drink? Yes No How much?_____

How often do you exercise and what do you do?_____