

PATIENT NAME: _____ DATE: _____

What is your **major** complaint? _____

When did your condition develop? _____

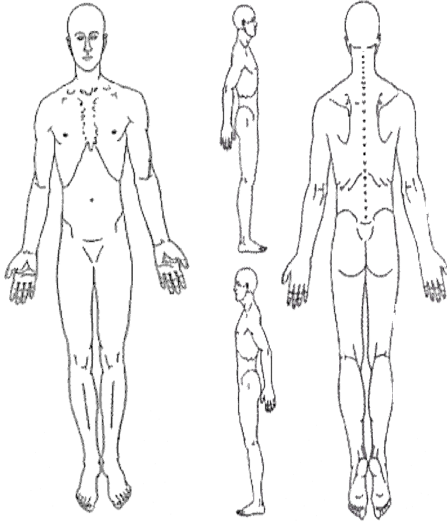
How did your condition develop? _____

Has your condition been getting better, staying the same or getting worse? _____

What makes your condition better? _____ What makes it worse? _____

Please mark the exact location of your pain on the diagram.

A = Ache	B = Burning	S = Stabbing
N = Numbing	P = Pins and Needles	O = Other



Do you currently or in the past have:		
Please mark all that apply:	When	# episodes
€ Back pain or stiffness	_____	_____
€ Neck pain or stiffness	_____	_____
€ Shoulder pain	_____	_____
€ Carpal Tunnel	_____	_____
€ Numbness, tingling or pain in the arms, hands, or fingers	_____	_____
€ Hip pain	_____	_____
€ Knee pain	_____	_____
€ Foot pain	_____	_____
€ Cold hands or feet	_____	_____
€ Numbness, tingling or pain in the legs, feet or toes	_____	_____

DATE OF LAST:	Less than 6 months	6-12 months	Over 12 months	Never
Spinal Examination				
Physical Examination				
Blood Test				
Spinal X-ray				
Other X-ray				
MRI / CT Scans				

HABITS:	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				

MEDICATIONS: Please list all medications currently taking.

Treatment you are receiving or have received for current condition:

- € Medical Care Who is your Primary Care Physician? _____
- € Chiropractic Care If yes, when and with whom? _____
- € Other (Please specify) _____

PATIENT NAME: _____ DATE: _____

HOSPITALIZATIONS, OPERATIONS, AUTO ACCIDENTS or WORK INJURIES – TREATMENT AND YEAR

1. _____
2. _____
3. _____
4. _____
5. _____

GENERAL	Current	Past
Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Chills	€	€
Dizziness	€	€
Fainting	€	€
Fatigue	€	€
Fever	€	€
Headache	€	€
Loss of Sleep	€	€
Loss of Weight	€	€
Nervousness/depression	€	€
Numbness	€	€
Seizures	€	€
Sweats	€	€
Tremors	€	€

EYES, EARS, NOSE	Current	Past
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Colds	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Ear noises	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>
Gum trouble	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Nasal obstruction	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>

Check the following conditions you have had.
<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Anemia
<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Diphtheria
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Goiter
<input type="checkbox"/> Gout
<input type="checkbox"/> Heart disease
<input type="checkbox"/> Influenza
<input type="checkbox"/> Malaria
<input type="checkbox"/> Measles
<input type="checkbox"/> Miscarriage
<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Mumps
<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Polio
<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Stroke
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Whooping cough

MUSCLE & JOINT	Current	Past
Arthritis	€	€
Bursitis	€	€
Fractured bones	€	€
Gout	€	€
Muscle weakness or paralysis	€	€
Painful Tailbone	€	€
Poor Posture	€	€
Sciatica	€	€
Spinal Curvature	€	€
Swollen Joints	€	€

CARDIO-VASCULAR & RESPIRATORY	Current	Past
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Difficult Breathing	<input type="checkbox"/>	<input type="checkbox"/>
Hardening of arteries	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Pain over heart	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>
Rapid heart beat	<input type="checkbox"/>	<input type="checkbox"/>
Slow heart beat	<input type="checkbox"/>	<input type="checkbox"/>
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>

GASTRO-INTESTINAL	Current	Past
Belching or Gas	€	€
Colon trouble	€	€
Constipation	€	€
Diarrhea	€	€
Difficult Digestion	€	€
Excessive hunger	€	€
Gall bladder trouble	€	€
Hernia	€	€
Hemorrhoids	€	€
Jaundice	€	€
Liver trouble	€	€
Nausea	€	€
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	€	€

GENITO – URINARY	Current	Past
Bed – wetting	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Inability to control urine	<input type="checkbox"/>	<input type="checkbox"/>
Kidney infections or stones	<input type="checkbox"/>	<input type="checkbox"/>
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>

SKIN	Current	Past
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Skin eruptions (rash)	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>

FOR WOMEN ONLY	Current	Past
Breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>
Cramps or backache	<input type="checkbox"/>	<input type="checkbox"/>
Excessive menstrual flow	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>
Irregular cycle	<input type="checkbox"/>	<input type="checkbox"/>
Menopausal symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Painful menstruation	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>