Last Name _____ First _____ Middle _____

Address _____ SS# _____-_____-_____ Birthdate_____/_____/_____ Age_____

City _____ State_____ Zip _____ DL# _____

Occupation_____ Employer _____ Spouse Occupation _____

☐Full Time ☐Part Time ☐Retired ☐Not Employed Employer _____

Children _____ Phone _____ Work _____ Cell _____ eMail _____

Contact in case of emergency _____ Referred By _____

MY GOAL FOR CONSULTING WITH THE DOCTOR: ☐Temporary relief ☐Lasting correction ☐Let doctor recommend the best type of care for you.

Major Complaint_____

_____Timing: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% of the time

How serious do you think you problem is? _____

On a scale of 0-10, how committed are you to getting rid of this problem? (0= not committed 10= totally committed) _____

What caused it? How did it start? (Gradual/Injury) _____

Have you had this or similar condition in the past? _____

☐ Constant ☐ Comes and goes _____ Is it progressively getting worse? ☐ Yes ☐ No

Medications you are on now_____

What makes it better? _____Worse? _____

Describe the problem when it is at its worst _____

How has this problem affected your life? _____

1. Difficulty in performing basic activates of daily living – ☐ bathing/showering ☐ shaving ☐ dressing ☐ other _____
2. Daily duties: difficulty in performing ☐ cleaning ☐ washing dishes ☐ sweeping mopping ☐ other _____
3. Hobbies: slowing or prevention of certain hobbies _____
4. Work: ☐ I just get through ☐ slower production due to pain ☐ cannot work at all
5. How does this problem affect your family/social life? _____

What activity would you like to be able to do again that is difficult or that you cannot do now? _____

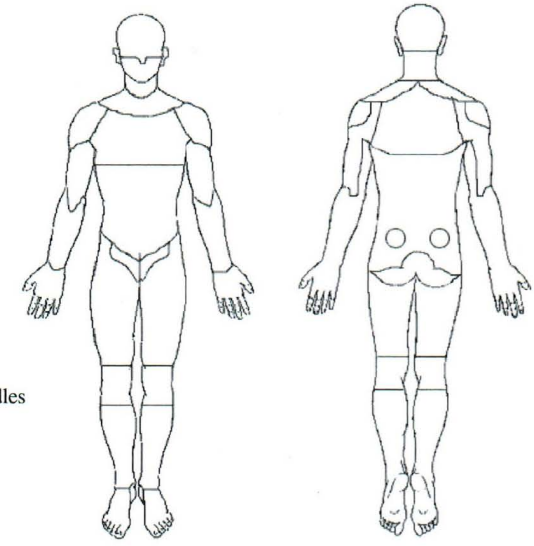
_____

Is this a new/old illness? Treatment? _____ Doctor _____

Mark any areas of pain on diagram.

Radiation
Arms
Hands
Legs
Feet

A=ache
B=burn
N=numbness
T=tight
S=sharp
D=dull
P=pins & needles
O=other



Rate the severity 0-10 _____ (0= no pain, 10=excruciating pain)

Please indicate with a (**C**) **CONDITIONS YOU HAVE NOW** or with a (**P**) conditions you have had **IN THE PAST**. If neither applies, mark (**NA**). Don't leave any blanks.

__Headaches
__Neck problem
__Shoulder problem
__Arm problem
__Numb arms/fingers
__Pain between shoulders
__Low back problem
__Leg problem
__Numb legs/toes
__Loss of feeling
__Stiff joints
__Painful joints
__Sore muscles
__Muscle cramps
__Broken bones
__Weak muscles
__Dizziness
__Memory problem
__Mental/emotion
__Extreme worry
__Depression
__Anxiety
__Insomnia
__Vision problem
__Ear infection
__Walking problem
__Hearing loss
__Freq colds
__Fatigue
__Allergies
__Hay fever
__Asthma
__Heart problem (Angina, MI,CAD,COPD,CHF)
__Blood Pressure High/Low
__Kidney problem
__Indigestion or nausea
__Ulcers
__Eczema
__Constipation
__Diarrhea
__Diabetes
__Menstrual cramps

ADL ☐ Restricts daily activities ☐ Restricts regular exercise ☐ Difficulty walking/standing/sitting ☐Household duties ☐Other

- Have you ever had surgery or been hospitalized?

_____

- When did you last see a chiropractor _____
  Doctor Name _____
- Last time you had spinal x-rays _____

Family History: List any conditions affecting your family: _____

_____

- Female: Are you pregnant at this time? ☐Yes ☐No Due Date _____

TRAUMA FROM BIRTH TO PRESENT. List by date/describe.

1. Injuries or falls _____

_____

2. Car/bike accidents _____

_____

3. Other _____

Sign & date:

DOCTORS USE ONLY)

CERVICAL

Date	Normal			
Flexion	50			
Extension	60			
Lat. R. Flex	45			
Lat. L. Flex	45			
Rotation Right	80			
Rotation Left	80			

LUMBAR

Date	Normal			
Flexion	50			
Extension	60			

Date						
	Left	Right	Left	Right	Left	Right
F. Compression						
Shoulder Depression						
Kemps						
Wrights/Adsons						
SLR						
Millgrams						
Toe Walk						
Heel Walk						
Leg Length Unequal						