Diagnostic Chiropractic

WELCOME to diagnostic chiropractic

ABOUT YOU

Name: _____ **D.O.B.** _____ **Todays Date:**
Home Address: _____ **City:** _____ **St.:** _____ **Zip:** _____
Home Phone #: _____ **Cell Phone #:** _____
Marital Status: Single Married Divorced Widowed **Spouse's Name**: _____
Employer: _____ **Address:** _____
City: _____ **State:** _____ **Zip:** _____ **Employer Phone #** _____
Have you ever been treated by a Chiropractor before: □Yes □ No
Referred By: _____ **Name you would like to be called:**_____

HEALTH HISTORY

List all medications: _____
_____

Have you ever had any of the following medical conditions?
□ Heart Disease □ Pacemaker □ Cancer □ HIV+/Aids □ Hepatitis □ Anemia □ Shingles □ Diabetes
□ High/Low Blood Pressure □ Kidney □ Alcohol/Drug Abuse □ Psychiatric □ Fainting/Seizures/Epilepsy □ Artificial Joints
Do you suffer from:
□ Severe/Frequent headaches □ Sinuses □ Asthma □ Difficulty breathing □Frequent neck pain □ Lower back problems

List any other serious medical conditions, surgeries, or past serious accidents, with dates, you may have or ever had:
1. _____
2. _____
3. _____
4. _____
Do you smoke: □Yes □ No **How much:** **Do you wear:** □ Heel lifts □ Sole lifts □ Inner soles □ Arch support
For women: Are you pregnant □Yes □ No If yes due date: **Do you take birth control**: □Yes □ No

REASON FOR VISIT

When did condition began? / / **Is visit a result of (Circle)** work, sports, auto, trauma, or chronic
Explain what happened:_____
_____
Describe the pain & its location: _____
_____
Is condition/symptoms: Getting Worse: □Yes □ No **Constant**: □Yes □ No **Comes & Goes**: □Yes □ No
Is condition/symptoms interfering with: Work □Yes □ No **Sleep** □Yes □ No **Daily routine** □Yes □ No
Have you had this or similar conditions in the past: □Yes □ No
If so explain:_____

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History of Current Symptoms

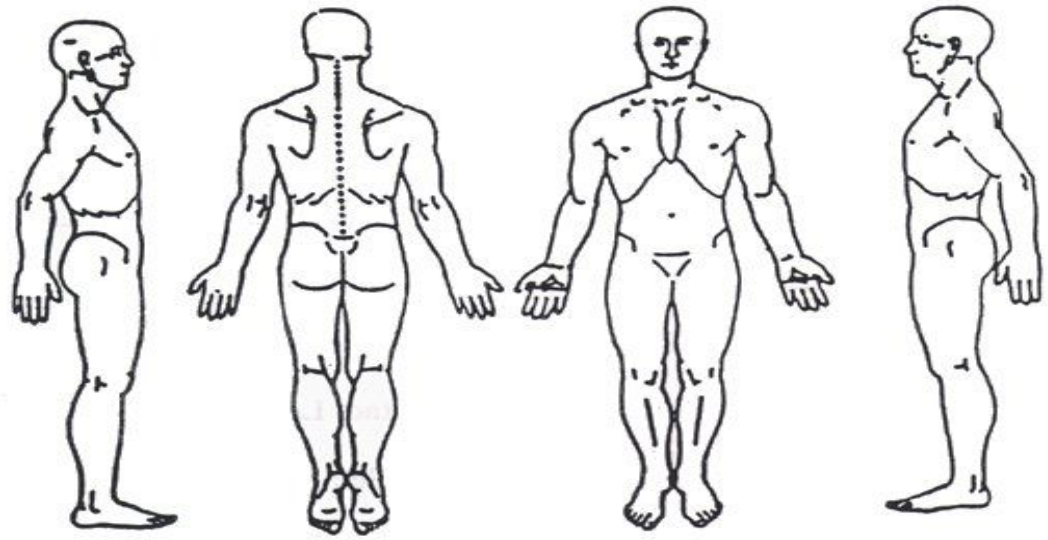
Have you seen any other doctor: □**Yes** □ **No** Dr. Name: _____
Was medication prescribed: □**Yes** □ **No** **Name of Medication:** _____
Have you been able to work since this injury: □**Yes** □ **No** **If no-last day you worked:**

Check if you have pain upon: □ Lying on back □ Lying on side □ Lying on stomach □ Sitting □ Standing □ Walking
□ Lifting □ Lifting □ Bending □ Working □ Pulling □ Reaching

What activities aggravate your problem area the most: _____
_____

SHOW US WHERE IT HURTS

Degree of pain (1 discomfort) to (10 extreme pain) 1 2 3 4 5 6 7 8 9 10 **(Circle)**
Frequency of pain: Intermittent (0%-25% of time) Occasional (26%-50%) Frequent (51%-75%) Constant (75%-100%)
Mark type of pain: Numbness/Tingling OOOO Burning ^ ^ ^ ^ Sharp or Stabbing **XXXX** Aching ****



RIGHT **BACK** **FRONT** **LEFT**

DOCTORS NOTES:

_____
_____
_____
_____
_____
_____

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