CONFIDENTIAL INFORMATION

PATIENT'S NAME: _____
DATE: _____

What is the problem that brought you here?

_____
_____

Do you suffer from any other disabling condition or physical impairments not due to this accident or illness?

_____
_____

Check the symptoms you have:

__Headache	__Irritability	__Fatigue	__Loss of Taste
__Neck pain	__Chest pain	__Depression	__Tension
__Neck stiff	__Dizziness	__Fever	__Loss of smell
__Sleeping problems	__Head seems heavy	__Diarrhea	
__Loss of memory	__Back pain	__Ears ring	
__Pins & needles in arms	__Pins & needles in legs	__Nervous	
__Numbness in fingers	__Numbness in toes	__Fainting	
__Face flushed	__Hands cold	__Feet cold	
__Buzzing in ears	__Feet sweats	__Constipation	
__Shortness of breath	__Other_____		

Have you ever suffered from?

__Dizziness	__Tuberculosis	__Epilepsy	__Asthma	__Neuritis	__Insomnia	__Heart trouble
__Arthritis	__Cancer	__Anemia	__Diabetes	__Fainting	__Sinus trouble	__Rheumatic fever
__Digestive disorders		__Backaches/Disc problems				

Date of last physical examination: _____

Operations you have had: _____
_____

What have you heard about chiropractic? _____
_____

Major complaint: _____
_____

Have you had this problem longer than a week or two? _____ Yes _____No
If yes, for how long? _____

Have you had this problem more than 2 or 3 times? _____ Yes _____No
If yes, how often? _____

What makes the problem worse? _____
_____

SEE OTHER SIDE

What have you tried to do to get rid of the problem that did not work? (i.e.: medications, ice, heat, diet)
_____
_____

Before you began to suffer with this problem, was there an earlier accident, injury or condition that could have brought this about or be related to it? (ie: fall, auto injury, work injury, sports trauma) _____Yes _____No
Please Describe_____
_____

Have you been worried at all about getting this problem handled? _____Yes_____No

Describe how it feels when the problem is at its worst _____
_____

Imagine how it feels when this problem is at its worst compared to a time when you feel great.
_____

How would this problem at its worst interfere with life:

Your ability to work? _____

Your ability to enjoy or be with your family or social life? _____

Your ability to participate and enjoy your hobbies? _____

When it is at its worst, how much older does this problem makes you feel?
_____

If left uncorrected, how much worse do you feel it will get in the next 5 years?
_____

On a scale of 1-10, ten being the highest, rate your commitment to getting rid of this problem
_____

Do you have children? _____Yes _____No

Names and ages: _____
_____

Comments or concerns:
_____
_____
_____
_____