COMMONWEALTH FAMILY CHIROPRACTIC

Dr. Paul W. Eriksen, D.C.

Date _____ Case Number _____

Tell Us About You

Title:_____ First:_____ MI:___ Last:_____

Nickname:_____ Birth date:_____ Age:_____ Sex: ❒ Male ❒ Female

Current address:_____

City:_____ State:_____ Zip:_____

SS #:_____-_____-_____ Email:_____

Home Phone:_____-_____-_____ Work Phone:_____-_____-_____Ext:_____

Mobile Phone:_____-_____-_____ Preferred contact: ❒ Home ❒ Work ❒ Cell

Whom may we thank for referring you?_____

Marital status: ❒ Single ❒ Divorced ❒ Widowed ❒ Married to:_____

# of children:_____ Ages of children:_____

❒ Full-time employment ❒ Part-time employment ❒ Self-employed ❒ Unemployed ❒ Retired

Occupation:_____ Employer:_____

❒ Full-time student ❒ Part-time student School name:_____

Alternate address:_____

City:_____ State:_____ Zip:_____ Parents/Other:_____

Emergency Contact:_____ Phone:_____-_____-_____

Your relationship to emergency contact:_____

Tell Us Why You're Here

What is the primary reason for your visit?_____

_____

Is this due to a: ❒ Automobile accident ❒ Work-related injury ❒ Personal injury case ❒ None

When did your pain/symptoms begin (include date if possible)?_____

The overall severity of your complaints/concerns is:

❒ Mild ❒ Mild to moderate ❒ Moderate ❒ Moderately severe ❒ Severe

The overall frequency is: ❒ Occasional ❒ Intermittent ❒ Frequent ❒ Constant

On a scale of 0 to 10, how would you rate your pain/symptoms today? (please circle a number below)

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible

Are your symptoms/pain getting: ❒ Better ❒ Worse ❒ Staying the same

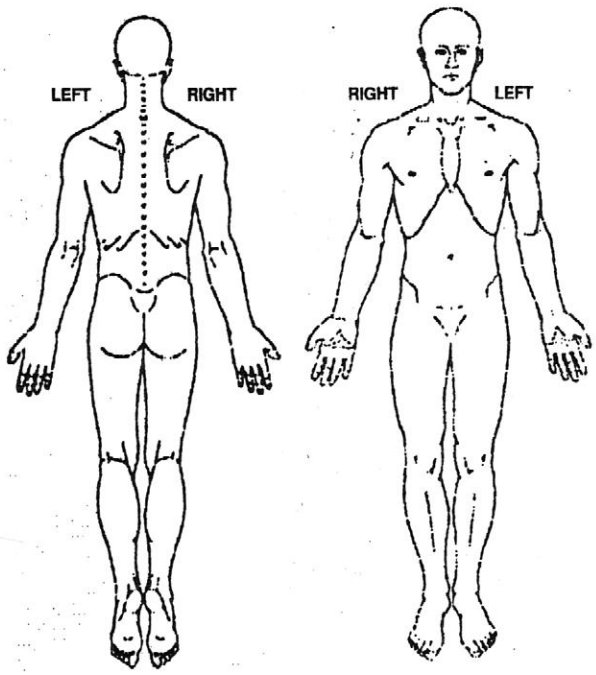
Have you had recent treatment for this condition? ❒ No ❒ Yes—please list dates and doctors:

Have you had the same or similar problems in the past? ❒ No ❒ Yes—When:_____

Do you have any additional complaints/concerns/health problems? ❒ No ❒ Yes—please describe:

Use the following key to mark your complaints on the diagram at the right:

Pain = **P**	Numbness = **N**	Weakness = **W**
Soreness = **O**	Stiffness = **X**	Swelling = **S**
Burning = **B**	Tingling = **T**	



If your complaints include pain, how would you describe it? (please check all that apply):

❒ Aching ❒ Burning ❒ Dull ❒ Sharp ❒ Shooting

❒ Stabbing ❒ Throbbing ❒ Other:_____

Do work activities aggravate your present complaints?

❒ Yes ❒ No

Please mark whether you NOW HAVE (O) or had IN THE PAST (❒) any of the following conditions/illnesses:

NOW HAVE	IN THE PAST		NOW HAVE	IN THE PAST		NOW HAVE	IN THE PAST	
O	❒	Allergies	O	❒	Difficulty Speaking	O	❒	Menstrual Problems or Pain
O	❒	Hay Fever	O	❒	Sinus Trouble	O	❒	Prostate Trouble
O	❒	Fatigue or Weakness	O	❒	Asthma	O	❒	Erectile Dysfunction
O	❒	Night Sweats	O	❒	Wheezing	O	❒	Fertility Problems
O	❒	Unexpected Weight Loss	O	❒	Chronic Cough	O	❒	Excessive Thirst
O	❒	Unexpected Weight Gain	O	❒	Shortness of Breath	O	❒	Thyroid Trouble
O	❒	Sleeping Problems	O	❒	Chest Pain or Pressure	O	❒	Anxiety or Nervousness
O	❒	Skin Problems	O	❒	Heart Trouble	O	❒	Mood Swings or Irritability
O	❒	Loss of Balance	O	❒	High Blood Pressure	O	❒	Mental or Emotional Difficulty
O	❒	Dizziness or Lightheadedness	O	❒	Low Blood Pressure	O	❒	Depression
O	❒	Vertigo	O	❒	Cold Hands or Feet	O	❒	Arthritis
O	❒	Fainting	O	❒	Abdominal Pain	O	❒	Bone Fracture
O	❒	Headaches	O	❒	Indigestion or Upset Stomach	O	❒	Dislocated Joints
O	❒	Seizures	O	❒	Excess Gas	O	❒	Autoimmune Disease
O	❒	Loss of Memory	O	❒	Heartburn	O	❒	Cancer
O	❒	Vision Trouble	O	❒	Constipation	O	❒	Diabetes
O	❒	Hearing Trouble	O	❒	Diarrhea	O	❒	Fibromyalgia
O	❒	Ear Infections	O	❒	Nausea or Vomiting	O	❒	Multiple Sclerosis
O	❒	Ringing or Buzzing in Ears	O	❒	Bedwetting	O	❒	Rheumatic Fever
O	❒	Loss of Smell	O	❒	Urinary Pain or Frequency	O	❒	Tuberculosis
O	❒	Loss of Taste	O	❒	Kidney or Bladder Trouble	O	❒	Other:_____
O	❒	Difficulty Swallowing	O	❒	Blood in Urine or Stool	O	❒	**No Conditions/Illnesses**

Your Activities of Daily Living and Work

Please indicate which activities of daily living are compromised by your current state of health:

General:	❒ Walking	❒ Standing	❒ Running	❒ Sports
	❒ Sitting	❒ Lifting children	❒ Bending	❒ Recreational activities
	❒ Climbing stairs	❒ Reading	❒ Lying in bed	❒ Getting into/out of an automobile
	❒ Chewing	❒ Swimming	❒ Using keyboard	❒ Sewing or crafts
	❒ Kneeling	❒ Playing instrument	❒ Exercising	❒ _____
	❒ Sleeping	❒ Using telephone	❒ Sitting in recliner	
Housework:	❒ Doing laundry	❒ Vacuuming	❒ Ironing	❒ Caring for pets
	❒ Making beds	❒ Washing dishes	❒ Carrying groceries	❒ Cooking
Yardwork:	❒ Mowing lawn	❒ Raking leaves	❒ Gardening	❒ Shoveling snow
Personal grooming:	❒ Combing hair	❒ Shaving	❒ In/out of bathtub	❒ Brushing teeth
Travel:	❒ Driving a car	❒ Riding in a car	❒ _____	❒ _____

How often does your job involve lifting? ❒ Never ❒ Occasionally ❒ Frequently ❒ Constantly

Other job requirements (please check all that apply): ❒ Bending ❒ Carrying ❒ Stooping

❒ Twisting ❒ Turning ❒ Walking ❒ Other:_____

What is your primary work position? ❒ Seated ❒ Standing ❒ Other:_____

Sickness, Injury and Accident History *(please include dates and descriptions)*

Accidents (include automobile, work-related, personal injury, slip and fall, or any serious injury):_____

Prior illnesses (other than colds and flu):_____

Surgeries and hospitalizations:_____

Are you currently taking ANY over-the-counter medication: ❒ No ❒ Yes—list name and for what condition.

Are you currently taking ANY prescription medication: ❒ No ❒ Yes—list name and for what condition.

DRUG	CONDITION	DRUG	CONDITION	DRUG	CONDITION

Remember to list ALL drugs including: aspirin, antibiotics, insulin, birth control pills, blood pressure pills, etc.