PATIENT ENTRANCE DATA

Date _____

Name_____ Social Security _____ Drivers License _____
Address _____ Age _____ Birth Date _____
E - Mail _____ Marital Status M S D W
Home Phone _____ Work Phone _____ Number Of Children _____
Employer _____ Job Activities _____
Occupation _____ _____
In case of emergency please contact. _____ Relation _____ Phone _____
Whom may we thank for referring you to our Center? _____

If you have no symptoms or complaints and are here for wellness services, please check (✓) here _____ "Wish to have Chiropractic Wellness Services" and skip filling in a major complaint below. Otherwise please fill out the full "Patient Entrance Data" form in as much detail as possible.

Purpose of this appointment (major complaint) _____
Date symptoms first appeared _____ Was this due to an Automobile Accident Y N Work Accident Y N
Ever had same or similiar condition Y N If yes when and describe _____
_____
Other doctors seen for this condition _____
Present M.D. _____ Date of last visit _____ Reason _____
Previous Chiropractor _____ Date of last visit _____ Results Good Fair Poor
Females: Is there any chance you are pregnant? Y N Date last menstrual period ended? _____

As a full spectrum Chiropractic and Holistic Health Center, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this Center, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis you have experienced physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most of the time the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

HAVE YOU SUFFERED FROM ?

Past	Current		Occasional	Frequent	Past	Current		Occasional	Frequent	Past	Current		Occasional	Frequent
☐	☐	Backaches	☐	☐	☐	☐	Allergies	☐	☐	☐	☐	Menstrual cramps	☐	☐
☐	☐	Neck pain or stiffness	☐	☐	☐	☐	Sinus problems	☐	☐	☐	☐	Irregular cycle	☐	☐
☐	☐	Headaches	☐	☐	☐	☐	Frequent colds	☐	☐	☐	☐	Light or heavy flow	☐	☐
		Arms or legs:			☐	☐	Earaches	☐	☐	☐	☐	Miscarriages	☐	☐
☐	☐	Radiating pain	☐	☐	☐	☐	Noise in the ears	☐	☐	☐	☐	Other female problems	☐	☐
☐	☐	Numbness	☐	☐	☐	☐	Dizziness	☐	☐			**Men**		
☐	☐	Cramps	☐	☐	☐	☐	Eye or vision problems	☐	☐	☐	☐	Prostate problems	☐	☐
☐	☐	Arthritis	☐	☐	☐	☐	Diabetes	☐	☐					
☐	☐	Gout	☐	☐	☐	☐	Low blood sugar	☐	☐	☐	☐	Sexually Transmitted Dx		
☐	☐	Curvature of spine	☐	☐	☐	☐	Digestive problems	☐	☐	☐	☐	Cancer		
☐	☐	Bursitis	☐	☐	☐	☐	Constipation	☐	☐	☐	☐	Stroke		
☐	☐	Foot trouble	☐	☐	☐	☐	Diarrhea	☐	☐	☐	☐	Multiple sclerosis		
☐	☐	Heart problems	☐	☐	☐	☐	Kidney or bladder prob.	☐	☐	☐	☐	Alcoholism		
☐	☐	Circulation problems	☐	☐	☐	☐	Difficulties with urination	☐	☐	☐	☐	Anemia		
☐	☐	Blood pressure problems	☐	☐	☐	☐	Difficulty sleeping	☐	☐	☐	☐	Tuberculosis		
☐	☐	Swelling of the ankles	☐	☐	☐	☐	Fatigue	☐	☐	☐	☐	Polio		
☐	☐	Lung or breathing prob.	☐	☐	☐	☐	Nervousness or depression	☐	☐	☐	☐	Epilepsy		

Please list ANY SIGNIFICANT ACCIDENTS / TRAUMAS you have had in your life time (When were they? The circumstances? What treatment, if any was given?) : _____

_____

_____

Please list ANY SURGERIES / HOSPITALIZATIONS you have had in your lifetime (When they were? The reason(s) for the surgeries? Any Complications?) : _____

_____

_____

Please list any medications you are currently taking and any long term or high dose medications you have taken in the past, the reason for the medication, and the time span on the medication. _____

_____

_____

_____

Lifestyle Choices & Habits

Alcohol (What kind? How often? How many drinks?) ; _____
Coffee (Reg or Decaf? How many cups? What time of day?) : _____
Tobacco (What kind? How much per day?) : _____
Excercise (What kind? Duration? How often?) : _____
Bowel Movements (How many per day? When? Easy or difficult? Loose or hard? Color?) : _____

_____

Sleep : Type (spring, air) and age of mattress : _____
Condition (Good or Worn) : _____ Comfortable or Not : _____
Positions you mostly sleep in : _____ Type, thickness, and number of pillows : _____
Quality of sleep (Number of hours per night? Interuptions per night? Trouble falling asleep or staying asleep?) : _____

_____

On a scale of 0 to 10 rate your stress level : Occupational : _____ Personal : _____
Current weight : _____Amount **Gained or Lost** (circle) within past year : _____
Are you wearing a heel lift? (Thickness and in which shoe) : _____
Orthotics (Rigid or flexible? Length of time you have worn it? Percent of the day you wear them?) :

_____

Family Health Profile:

At our Chiropractic Center we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please describe below any health conditions or concerns you may have about your:

Children _____
Spouse _____
Mother _____
Father _____
Brothers _____
Sisters _____
Others _____

What do you want to accomplish at ABA Family Chiropractic Center? What are your goals?

1) _____ 3) _____
2) _____ 4) _____

What percent are you committed to getting and staying well? _____

The statements made on this form are accurate to the best of my recollection, and I agree to be examined at ABA Family Chiropractice Center for further evaluation : _____

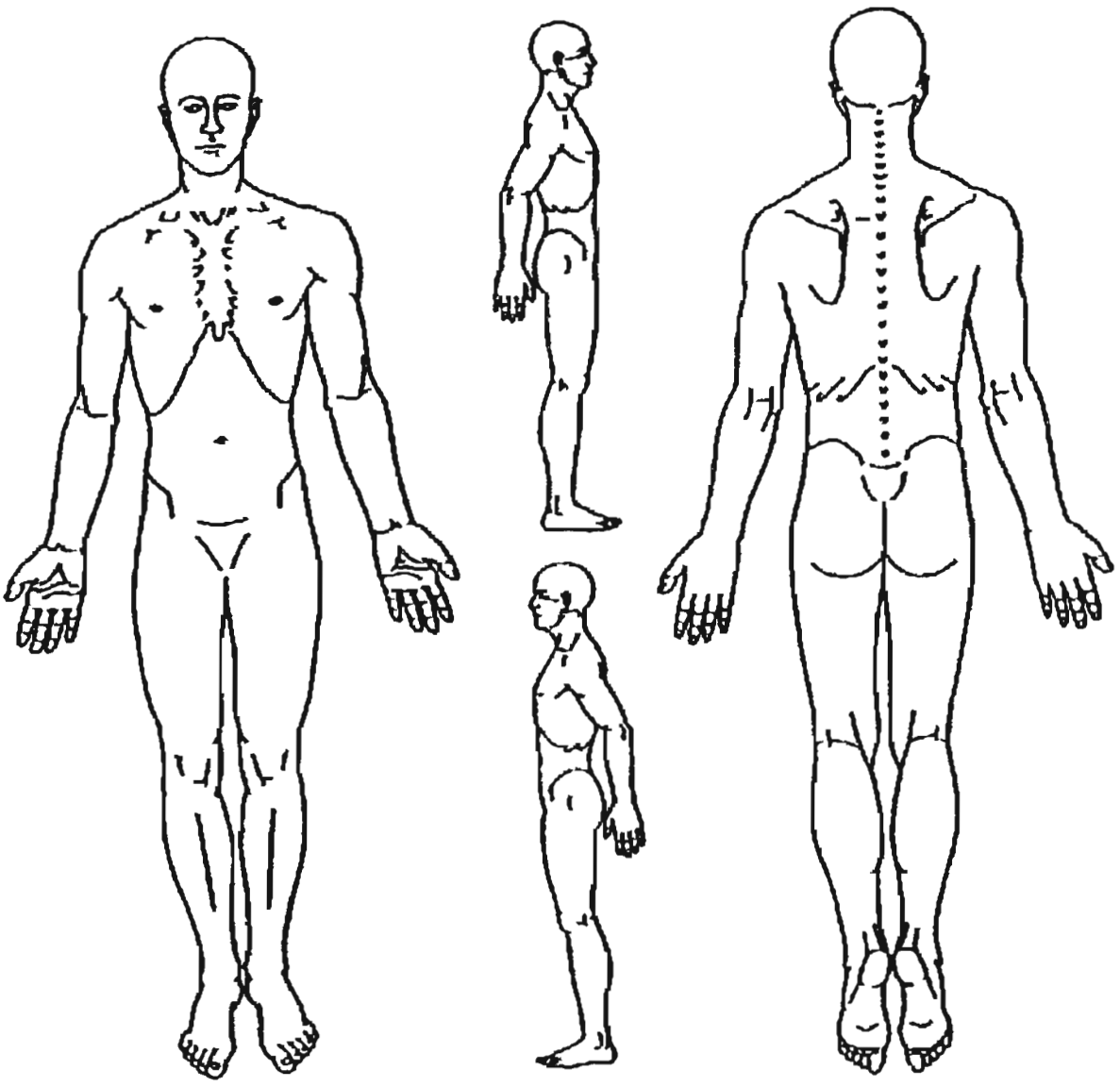
(Signature)

SYMPTOM SURVEY FORM - PAGE 5

Use the letters listed below to indicate the type and location of your pain and sensations

KEY

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____

FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Patient_____ DATE: _____

Please review the below-listed diseases and conditions and indicate those that are current health problems of a family member. Leave blank those spaces that do not apply. If you require more space use the reverse side of this form.

CONDITION	FATHER Age( )	MOTHER Age( )	SPOUSE Age( )	BROTHER(s) Age( ) Age( )	SISTERS(s) Age( ) Age( )	CHILDREN Age( ) Age( ) Age( )
Arthritis						
Asthma-Hay Fever-Allergies						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pres./ High Cholesterol						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neck Problems						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

_____