

С	ID#
L T	INS
ABR	Y/N

PERSONAL INFORMATION

Full Name :								Gend	ler: Male	Female	
Address :				City:			State:		Zip Code:		
Date of Birth :		Age:	Last 4 SSN:		Mari	ital Status	s: Single	Marrie	dWidowe	dDivorce	d
Email :					Cell Phone	э:					
Occupation:					Employer:						
Spouse's Name:					Number o	of Childrer	ו:				
Names & Ages of Children:											
Who may we thar	nk for referring you?										

CURRENT HEALTH

What major health concerns bring you int	to our office?				
When did the condition(s) first begin?					
Have you received care for this problem b	efore? Ves No - If yes, when?				
If Yes: Chiropractor Medical Doctor Other:					
If Yes: Who?	Results?				
How did the problem(s) start? Suddenly Gradually Post-Injury					
This condition is: OGetting Worse Im	proving Intermittent Constant Unsure				

What makes the problem better?

What makes it worse?

 Headaches Migraines Jaw/TMJ Pain Neck Pain Shoulder Pain Shoulder Pain Upper Back Pain Upper Back Pain Lower Back Pain Lower Back Pain Foot Pain Foot Pain Tight/Sore Muscles Ear Infections Hearing Loss Ringing in the Ears 	 , , , , , , , , , , , , , , , , , , ,	 GERD/Gastric Reflux Diarrhea Constipation Bed Wetting Bladder Problems Pregnant Infertility Menstrual Problems Prostate Problems Sexual Dysfunction Diabetes Stroke Arthritis Fibromyalgia Chest Pain 	 , , , , , , , , , , , , , , , , , , ,
		Other:	

List all surgical operations & years:
List all over the counter & prescription medications you are on, & the reason for each: (May use back of this page)
Other trauma:
List any other injuries to your spine, minor or major, that the doctor should know about:
Have you ever been in an auto accident? List all:
Do you have an open auto accident claim? Ves No
Have you ever been knocked unconscious? Yes No Fractured a bone? Yes No
If yes to either of the above, please describe:
Are you military or first responder? (Active or Retired)
Did you receive the COVID-19 injection? Yes No

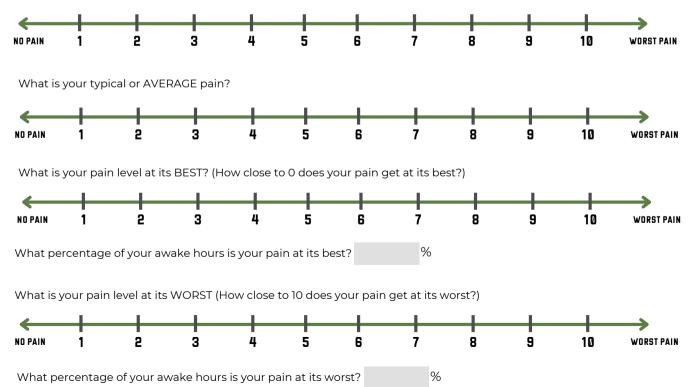
SOCIAL HISTORY

—
Smoking: How often? Daily Weekends Occasionally Never
Alcohol: How often? Daily Weekends Occasionally Never
Exercise: How often? Daily Weekends Occasionally Never
Have you consumed any caffeine or caffeine products within the past 48 hours? Ves No

QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

How would you rate your pain right now?



ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Carrying Groceries		nful (can do)	Painful (limits)	Unable to Perform
		, , , , , , , , , , , , , , , , , , ,	· · · ·	
Sit to Stand	No Effect Pai	nful (can do)	Painful (limits)	Unable to Perform
Climbing Stairs	No Effect Pai	nful (can do)	Painful (limits)	Unable to Perform
Pet Care	No Effect Pai	nful (can do)	Painful (limits)	Unable to Perform
Driving	No Effect Pai	nful (can do)	Painful (limits)	Unable to Perform
Extended Computer Use	No Effect Pai	nful (can do)	Painful (limits)	Unable to Perform
Household Chores	No Effect Pai	nful (can do)	Painful (limits)	Unable to Perform
Lifting Children	No Effect Pai	nful (can do)	Painful (limits)	Unable to Perform
Dressing	No Effect Pai	nful (can do)	Painful (limits)	Unable to Perform
Washing/Bathing	No Effect Pai	nful (can do)	Painful (limits)	Unable to Perform
Sexual Activities	No Effect Pai	nful (can do)	Painful (limits)	Unable to Perform
Sleep	No Effect Pai	nful (can do)	Painful (limits)	Unable to Perform
Sitting	No Effect Pai	nful (can do)	Painful (limits)	Unable to Perform
Standing	No Effect Pai	nful (can do)	Painful (limits)	Unable to Perform
Walking	No Effect Pai	nful (can do)	Painful (limits)	Unable to Perform
Yard Work	No Effect Pai	nful (can do)	Painful (limits)	Unable to Perform
Other:	Pai	nful (can do)	Painful (limits)	Unable to Perform
Other:	Pai	nful (can do)	Painful (limits)	Unable to Perform

How has your health affected your life in a negative way?

If your body was functioning and adapting better, what are 2 things you would be able to do?

FAMILY HEALTH HISTORY

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss of Energy					
Nervousness	,				
Blurred/Double Vision	,				
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer's					