SIMPLE
WELL BEING
CHIROPRACTIC | ACUPUNCTURE | NUTRITION
Wilmington NC

For Office Use Only
Date: _____
Acct #:_____
Patient Height _____
Patient Weight _____
Patient BMI _____
Patient Blood Pressure _____

Name: _____

Race (circle only 1) American Indian Alaska Native Asian White Black/African American Native Hawaiian Other Decline Answering

Ethnicity (circle only 1) Declined to State Hispanic or Latino Not Hispanic or Latino

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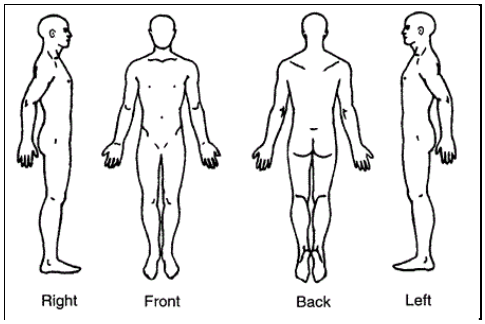
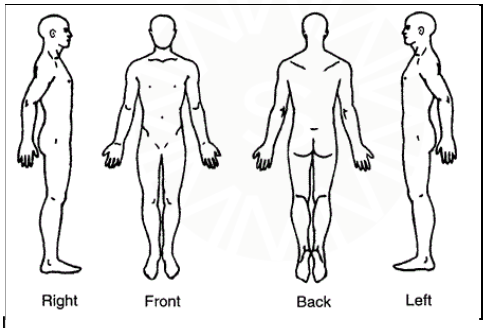
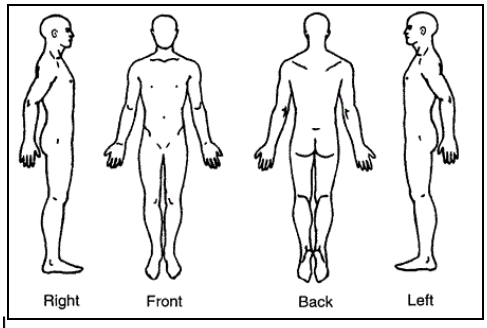
Have you ever received chiropractic care? Yes No If Yes, when? _____

Location (Where does it hurt?) CIRCLE the area on the illustration.

Symptom 1:	Symptom 2:	Symptom 3:
		
Intensity: Circle 1 2 3 4 5 6 7 8 9 10 Absent Uncomfortable Agonizing	Intensity: Circle 1 2 3 4 5 6 7 8 9 10 Absent Uncomfortable Agonizing	Intensity: Circle 1 2 3 4 5 6 7 8 9 10 Absent Uncomfortable Agonizing
Duration: When did it start? _____	Duration: When did it start? _____	Duration: When did it start? _____
How often: Constant (75-100% present) Frequent (50-75% present) Occasional (25-50% present)	How often: Constant (75-100% present) Frequent (50-75% present) Occasional (25-50% present)	How often: Constant (75-100% present) Frequent (50-75% present) Occasional (25-50% present)
Radiation: Affect other areas? Where does it radiate, shoot or travel?	Radiation: Affect other areas? Where does it radiate, shoot or travel?	Radiation: Affect other areas? Where does it radiate, shoot or travel?
Aggravating or relieving factors: What makes it better or worse; time of day, movement?	Aggravating or relieving factors: What makes it better or worse; time of day, movement?	Aggravating or relieving factors: What makes it better or worse; time of day, movement?
Prior interventions: (what have you tried to relieve this symptom? Prescription meds Physical Therapy OTC Medication Massage Therapy Chiropractic Ice/ Heat Homeopathic Remedies Surgery	Prior interventions: (what have you tried to relieve this symptom? Please Circle All Prescription meds Physical Therapy OTC Medication Massage Therapy Chiropractic Ice/ Heat Homeopathic Remedies Surgery	Prior interventions: (what have you tried to relieve this symptom? Prescription meds Physical Therapy OTC Medication Massage Therapy Chiropractic Ice/ Heat Homeopathic Remedies Surgery

Print Name: _____ DOB: _____ Account #: _____

What else should the doctor know about your current condition/symptoms?

_____

Do you suffer from any condition other than that for which you are now consulting us? ☐Yes ☐No If yes, please describe:

_____

List any PAST conditions you may have had: _____

MEDICAL HISTORY

DATE OF LAST PHYSICAL EXAMINATION: _____

Please check the box for each CURRENT or past symptom listed

GENERAL SYMPTOMS

☐ Allergy(What) ____
_____
☐ Bronchitis
☐ Chills (Constant)
☐ Convulsions
☐ Dizziness
☐ Fainting
☐ Fatigue
☐ Headache
☐ Loss of Sleep
☐ Loss of Weight
☐ Nervousness
☐ Night Sweats
☐ Numbness or Pain in arms/legs/hands
☐ Wheezing

MUSCLES & JOINTS

☐ Backache
☐ Foot Trouble
☐ Hernia
☐ Pain Between Shoulders
☐ Painful Tail Bone
☐ Stiff Neck
☐ Spinal Curvature
☐ Swollen Joints

GASTRO-INTESTINAL

☐ Belching or Gas
☐ Colon Trouble
☐ Constipation
☐ Diarrhea
☐ Gall Bladder Trouble
☐ Hemorrhoids (piles)
☐ Jaundice
☐ Liver Trouble
☐ Nausea
☐ Stomach Pain
☐ Vomiting
☐ Vomiting Blood
☐ Heart Burn
☐ Bloody Stools
☐ Acid Reflux
☐ Irritable Bowel

CARDIO-VASCULAR

☐ High Blood Pressure
☐ Low Blood Pressure
☐ Chest Pain
☐ Heart Trouble
☐ Poor Circulation
☐ Rapid Heart
☐ Slow Heart
☐ Strokes
☐ Swelling Ankles

EYE/EAR NOSE/THROAT

☐ Asthma
☐ Deafness
☐ Earache
☐ EarDischarge
☐ EarNoises
☐ Thyroid
☐ Problems
☐ FrequentColds
☐ Hay Fever
☐ NasalObstruction
☐ Nose Bleeds
☐ Pain in Eyes
☐ PoorVision
☐ BlurredVision
☐ Sinusitis
☐ SoreThroats
☐ Tonsillitis

SKIN OR ALLERGIES

☐ Dryness
☐ Eczema
☐ Hives or Allergy
☐ Itching
☐ SensitiveSkin
☐ Skin Eruptions
☐ Bruising Easily

RESPIRATORY

☐ Chest Pain
☐ Chronic Cough
☐ Difficulty Breathing
☐ Spitting Blood
Spitting Phlegm

GENITO-URINARY

☐ Bed Wetting
☐ Blood in Urine
☐ Frequent Urination
☐ Inability to Control Urine
☐ Kidney Infection
☐ Kidney Stones
☐ Painful Urination
☐ Prostate Trouble

FOR FEMALES ONLY

☐ Cramps
☐ Hot Flashes
☐ Irregular Cycle
☐ Painful Periods
☐ Vaginal Discharge
☐ Pregnant Now?

_____ Last Pap Date
_____ Last Menstrual Cycle

PRINT NAME: _____ DOB: _____ ACCOUNT #: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

Appendicitis	Anemia	Heart Disease	Arthritis	Pneumonia	Measles
Goiter	Epilepsy	Rheumatic Fever	Mumps	Influenza	Mental Disorder
Polio	Chicken Pox	Pleurisy	Lumbago	Tuberculosis	Diabetes
Alcoholism	Eczema	Whooping Cough	Cancer	Venereal Disease	HIV Positive

Have you ever had any surgeries?__Yes __No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
_____	Back Operation	_____	Hernia	_____	Gall Bladder
_____	Female Organs	_____	Thyroid	_____	Stomach

Other _____

Have you ever had X-rays taken? ___Yes ___No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

Are you taking any medication (prescription or over-the-counter)? _Yes _No

If Yes, please indicate the following:

Medication: _____ Medication: _____

Route: Oral Route: Oral
Intravenous Intravenous
Other: _____ Other: _____
Frequency: _____ Frequency: _____
Began Use: _____ Began Use: _____
Discontinued Use: _____ Discontinued Use: _____

Medication: _____ Medication: _____

Route: Oral Route: Oral
Intravenous Intravenous
Other: _____ Other: _____
Frequency: _____ Frequency: _____
Began Use: _____ Began Use: _____
Discontinued Use: _____ Discontinued Use: _____

Have you taken any medications in the past? __Yes __No If yes, which ones?: _____

Have you taken Levoquin or Cipro in the past 12 months? YES NO
Are you currently taking Birth Control? YES NO

List any supplements you are taking: _____

Do you have allergies to medication? __Yes __No
If Yes, please indicate the following:

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____
Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

PRINT NAME: _____ DOB: _____ ACCOUNT #: _____

SOCIAL HISTORY

Caffeine use: ☐ Never ☐ Occasional ☐ Often

Drink alcohol: ☐ Never ☐ Occasional ☐ Often

Chew tobacco: ☐ Never ☐ Occasional ☐ Often

Cigarettes: Exercise: ☐ Never ☐ Occasional ☐ Often

Wear Seat Belts: ☐ Never ☐ Occasional ☐ Often

	Diabetes	Cancer	Back Pain	Hypertension	Stroke	Thyroid	Heart Disease	Other
Mother								
Father								
Siblings								

WORK HISTORY: Circle all that Apply

Food Service Industry Business Owner Medium Manual Labor Computer User Clerical/Secretary

Construction Administration Heavy Equip. Operator Home Services Executive/Legal

Heavy Manual Labor Health Light Manual Labor House Keeper Manufacturing

Other: _____

What type of activities does your work involve? Circle all that apply

Sitting Standing Bending Turning Twisting Lifting Pulling/Pushing Other: _____

Are you currently pregnant? Yes No Do you have a pacemaker? Yes No

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I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care in accordance with this state's statutes. I understand that it is my responsibility to bring to the attention of the providing physician ANY new information regarding my health and well-being or any changes in health status that would be pertinent to my case management.

Patient's/Guardian's Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Account #: _____

PRINT NAME: _____ DOB: _____ ACCOUNT #: _____