Ballenger Creek Chiropractic

604 Solarex Ct Ste 101, Frederick, MD 21703

Phone: 301-620-1008

Patient Information:

Date		SSN		Birthday	
First Name		Middle Name		Last Name	
Sex	◯ Male ◯ Female	Height		Weight	
Married/Civil Union:		Spouse Name		# of Children	
Home #		Cell #		Work #	
Address					
City		State		Zip	
Emergency Contact		Emergency Relation		Emergency Phone	
Email					

Complaint Information:

What is the purpose of your visit? _____ What is the reason for this visit? _____

Date of scheduled appointment _____ When did this condition begin? _____

How long have you had this condition? _____ What caused this condition? _____

Where is the discomfort? Choose all that apply.

Head: ☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

Neck: ☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

Back: ☐ Right mid back ☐ Left mid back ☐ Central mid back ☐ Right low back ☐ Left low back ☐ Central low back

Trunk: ☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs

Upper Extremity:	☐ Front of right upper extremity	☐ Rear of right upper extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shoulder	☐ Rear of left shoulder
	☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
	☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
	☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
	☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand
Lower Extremity	☐ Front of right lower extremity	☐ Rear of right lower extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
	☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
	☐ Front of right knee	☐ Rear of right knee	☐ Front of left knee	☐ Rear of left knee
	☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
	☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear of left ankle
	☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
	☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot
	☐ OTHER			

Does the discomfort radiate/travel? ○ Yes ○ No

Where does the pain radiate to? Choose all that apply; choose non-radiating if none apply.

☐ Non-radiating			
☐ Front of left chest	☐ Front of right chest	☐ Front of left abdomen/groin	☐ Front of right abdomen/groin
☐ Front of left thigh	☐ Front of left lower leg	☐ Radiating to top of left foot	☐ Front of left shoulder
☐ Front of left upper arm	☐ Front of left lower arm	☐ Front of left hand	☐ Front of left face
☐ Front of right thigh	☐ Front of right lower leg	☐ Radiating to top of right foot	☐ Front of right shoulder
☐ Front of right upper arm	☐ Front of right lower arm	☐ Front of right hand	☐ Front of right face
☐ Back of left thigh	☐ Back of left lower leg	☐ Bottom of left foot	☐ Back of left shoulder
☐ Back of left upper arm	☐ Back of left lower arm	☐ Back of left hand	☐ Back of left side of head
☐ Back of right thigh	☐ Back of right lower leg	☐ Bottom of right foot	☐ Back of right shoulder
☐ Back of right upper arm	☐ Back of right lower arm	☐ Back of right hand	☐ Back of right side of head

Describe the quality of the discomfort. Choose all that apply.

☐ Aching	☐ Annoying	☐ Burning	☐ Deep	☐ Diffuse	☐ Dull
☐ Heavy	☐ Intolerable	☐ Pulling	☐ Sharp	☐ Shock-like	☐ Shooting
☐ Stabbing	☐ Stiffness	☐ Throbbing	☐ Tightness	☐ Tingling	☐ OTHER

Complaint #1 Information (2):

Onset of discomfort: ○ Gradual ○ Insidious ○ Recent ○ Spontaneous ○ Sudden ○ Traumatic ○ Unknown

Intensity of discomfort: ○ Mild ○ Mild to moderate ○ Moderate ○ Moderate to severe ○ Severe

Severity of discomfort: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Frequency of discomfort: ○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring

How has severity of the complaint changed since the onset? ○ Improved ○ Stayed the same ○ Worsened

What activity is most significantly affected by this discomfort? _____

What improves this condition? Choose all that apply.

☐ Chiropractic adjustment ☐ Cold packs ☐ Exercise ☐ Heat packs ☐ Massage
☐ Nothing ☐ OTC medications ☐ Physical therapy ☐ Prescription medication ☐ Re-direct attention
☐ Rest ☐ Stretching ☐ Work ☐ OTHER

What treatment have you received for this condition up to now?

☐ None ☐ Acupuncture ☐ Chiropractic care ☐ Craniosacral therapy ☐ Homeopathic medicine
☐ Hypnosis ☐ Injection therapy ☐ Medical care ☐ Naturopathic medicine ☐ Nutritional supplements
☐ Occupational therapy ☐ Osteopathic medicine ☐ OTC medications ☐ Physical therapy ☐ Prescribed medications
☐ Psychotherapy ☐ Reiki ☐ Surgery ☐ OTHER

Were any diagnostic tests performed to assess this condition (including X-rays, MRIs, etc.)? ○ Yes ○ No ○ Unsure

Have you ever had any previous episodes of this condition? ○ Yes ○ No

In what ways does this condition affect your life and your ability to function? Choose all that apply.

☐ Bending over ☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing myself
☐ Driving a car ☐ Exercising ☐ Getting in/out of car ☐ Getting to sleep ☐ Grocery shopping
☐ Household chores ☐ Lifting objects ☐ Looking over shoulder ☐ Love life ☐ Lying down
☐ Reaching overhead ☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing
☐ Staying asleep ☐ Using a computer ☐ Walking ☐ Yardwork

Do you have an additional complaint? ○ Yes ○ No

Complaint #2 Information:

What is the purpose of your visit? _____ What is the reason for this visit? _____

What caused this condition? _____ When did this condition begin? _____

How long have you had this condition? _____

Where is the discomfort? Choose all that apply.

Head: ☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

Neck: ☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

Back: ☐ Right mid back ☐ Left mid back ☐ Central mid back ☐ Right low back ☐ Left low back ☐ Central low back

Trunk: ☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs

Upper Extremity:	☐ Front of right upper extremity	☐ Rear of right upper extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shoulder	☐ Rear of left shoulder
	☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
	☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
	☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
	☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand
Lower Extremity	☐ Front of right lower extremity	☐ Rear of right lower extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
	☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
	☐ Front of right knee	☐ Rear of right knee	☐ Front of left knee	☐ Rear of left knee
	☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
	☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear of left ankle
	☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
	☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot
	☐ OTHER			

Does the discomfort radiate/travel? ○ Yes ○ No

Where does the pain radiate to? Choose all that apply; choose non-radiating if none apply.

☐ Non-radiating			
☐ Front of left chest	☐ Front of right chest	☐ Front of left abdomen/groin	☐ Front of right abdomen/groin
☐ Front of left thigh	☐ Front of left lower leg	☐ Radiating to top of left foot	☐ Front of left shoulder
☐ Front of left upper arm	☐ Front of left lower arm	☐ Front of left hand	☐ Front of left face
☐ Front of right thigh	☐ Front of right lower leg	☐ Radiating to top of right foot	☐ Front of right shoulder
☐ Front of right upper arm	☐ Front of right lower arm	☐ Front of right hand	☐ Front of right face
☐ Back of left thigh	☐ Back of left lower leg	☐ Bottom of left foot	☐ Back of left shoulder
☐ Back of left upper arm	☐ Back of left lower arm	☐ Back of left hand	☐ Back of left side of head
☐ Back of right thigh	☐ Back of right lower leg	☐ Bottom of right foot	☐ Back of right shoulder
☐ Back of right upper arm	☐ Back of right lower arm	☐ Back of right hand	☐ Back of right side of head

Describe the quality of the discomfort. Choose all that apply.

☐ Aching	☐ Annoying	☐ Burning	☐ Deep	☐ Diffuse	☐ Dull
☐ Heavy	☐ Intolerable	☐ Pulling	☐ Sharp	☐ Shock-like	☐ Shooting
☐ Stabbing	☐ Stiffness	☐ Throbbing	☐ Tightness	☐ Tingling	☐ OTHER

Complaint #2 Information (2):

Onset of discomfort: ○ Gradual ○ Insidious ○ Recent ○ Spontaneous ○ Sudden ○ Traumatic ○ Unknown

Intensity of discomfort: ○ Mild ○ Mild to moderate ○ Moderate ○ Moderate to severe ○ Severe

Severity of discomfort: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Frequency of discomfort: ○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring

How has severity of the complaint changed since the onset? ○ Improved ○ Stayed the same ○ Worsened

What activity is most significantly affected by this discomfort? _____

What improves this condition? Choose all that apply.

- ☐ Chiropractic adjustment ☐ Cold packs ☐ Exercise ☐ Heat packs ☐ Massage
- ☐ Nothing ☐ OTC medications ☐ Physical therapy ☐ Prescription medication ☐ Re-direct attention
- ☐ Rest ☐ Stretching ☐ Work ☐ OTHER

What treatment have you received for this condition up to now?

- ☐ None ☐ Acupuncture ☐ Chiropractic care ☐ Craniosacral therapy ☐ Homeopathic medicine
- ☐ Hypnosis ☐ Injection therapy ☐ Medical care ☐ Naturopathic medicine ☐ Nutritional supplements
- ☐ Occupational therapy ☐ Osteopathic medicine ☐ OTC medications ☐ Physical therapy ☐ Prescribed medications
- ☐ Psychotherapy ☐ Reiki ☐ Surgery ☐ OTHER

Were any diagnostic tests performed to assess this condition (including X-rays, MRIs, etc.)? ○ Yes ○ No ○ Unsure

Have you ever had any previous episodes of this condition? ○ Yes ○ No

In what ways does this condition affect your life and your ability to function? Choose all that apply.

- ☐ Bending over ☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing myself
- ☐ Driving a car ☐ Exercising ☐ Getting in/out of car ☐ Getting to sleep ☐ Grocery shopping
- ☐ Household chores ☐ Lifting objects ☐ Looking over shoulder ☐ Love life ☐ Lying down
- ☐ Reaching overhead ☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing
- ☐ Staying asleep ☐ Using a computer ☐ Walking ☐ Yardwork

Do you have an additional complaint? ○ Yes ○ No

Complaint #3 Information:

What is the purpose of your visit? _____ What is the reason for this visit? _____

What caused this condition? _____ When did this condition begin? _____

How long have you had this condition? _____

Where is the discomfort? Choose all that apply.

Head: ☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

Neck: ☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

Back: ☐ Right mid back ☐ Left mid back ☐ Central mid back ☐ Right low back ☐ Left low back ☐ Central low back

Trunk: ☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs

Upper Extremity:	☐ Front of right upper extremity	☐ Rear of right upper extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shoulder	☐ Rear of left shoulder
	☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
	☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
	☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
	☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand
Lower Extremity	☐ Front of right lower extremity	☐ Rear of right lower extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
	☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
	☐ Front of right knee	☐ Rear of right knee	☐ Front of left knee	☐ Rear of left knee
	☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
	☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear of left ankle
	☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
	☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot
	☐ OTHER			

Does the discomfort radiate/travel? ○ Yes ○ No

Where does the pain radiate to? Choose all that apply; choose non-radiating if none apply.

☐ Non-radiating			
☐ Front of left chest	☐ Front of right chest	☐ Front of left abdomen/groin	☐ Front of right abdomen/groin
☐ Front of left thigh	☐ Front of left lower leg	☐ Radiating to top of left foot	☐ Front of left shoulder
☐ Front of left upper arm	☐ Front of left lower arm	☐ Front of left hand	☐ Front of left face
☐ Front of right thigh	☐ Front of right lower leg	☐ Radiating to top of right foot	☐ Front of right shoulder
☐ Front of right upper arm	☐ Front of right lower arm	☐ Front of right hand	☐ Front of right face
☐ Back of left thigh	☐ Back of left lower leg	☐ Bottom of left foot	☐ Back of left shoulder
☐ Back of left upper arm	☐ Back of left lower arm	☐ Back of left hand	☐ Back of left side of head
☐ Back of right thigh	☐ Back of right lower leg	☐ Bottom of right foot	☐ Back of right shoulder
☐ Back of right upper arm	☐ Back of right lower arm	☐ Back of right hand	☐ Back of right side of head

Describe the quality of the discomfort. Choose all that apply.

☐ Aching	☐ Annoying	☐ Burning	☐ Deep	☐ Diffuse	☐ Dull
☐ Heavy	☐ Intolerable	☐ Pulling	☐ Sharp	☐ Shock-like	☐ Shooting
☐ Stabbing	☐ Stiffness	☐ Throbbing	☐ Tightness	☐ Tingling	☐ OTHER

Complaint #3 Information (2):

Onset of discomfort: ○ Gradual ○ Insidious ○ Recent ○ Spontaneous ○ Sudden ○ Traumatic ○ Unknown

Intensity of discomfort: ○ Mild ○ Mild to moderate ○ Moderate ○ Moderate to severe ○ Severe

Severity of discomfort: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Frequency of discomfort: ○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring

How has severity of the complaint changed since the onset? ○ Improved ○ Stayed the same ○ Worsened

What activity is most significantly affected by this discomfort? _____

What improves this condition? Choose all that apply.

☐ Chiropractic adjustment ☐ Cold packs ☐ Exercise ☐ Heat packs ☐ Massage
☐ Nothing ☐ OTC medications ☐ Physical therapy ☐ Prescription medication ☐ Re-direct attention
☐ Rest ☐ Stretching ☐ Work ☐ OTHER

What treatment have you received for this condition up to now?

☐ None ☐ Acupuncture ☐ Chiropractic care ☐ Craniosacral therapy ☐ Homeopathic medicine
☐ Hypnosis ☐ Injection therapy ☐ Medical care ☐ Naturopathic medicine ☐ Nutritional supplements
☐ Occupational therapy ☐ Osteopathic medicine ☐ OTC medications ☐ Physical therapy ☐ Prescribed medications
☐ Psychotherapy ☐ Reiki ☐ Surgery ☐ OTHER

Were any diagnostic tests performed to assess this condition (including X-rays, MRIs, etc.)? ○ Yes ○ No ○ Unsure

Have you ever had any previous episodes of this condition? ○ Yes ○ No

In what ways does this condition affect your life and your ability to function? Choose all that apply.

☐ Bending over ☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing myself
☐ Driving a car ☐ Exercising ☐ Getting in/out of car ☐ Getting to sleep ☐ Grocery shopping
☐ Household chores ☐ Lifting objects ☐ Looking over shoulder ☐ Love life ☐ Lying down
☐ Reaching overhead ☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing
☐ Staying asleep ☐ Using a computer ☐ Walking ☐ Yardwork

Do you have an additional complaint? ○ Yes ○ No

Complaint #4 Information:

What is the purpose of your visit? _____ What is the reason for this visit? _____

What caused this condition? _____ When did this condition begin? _____

How long have you had this condition? _____

Where is the discomfort? Choose all that apply.

Head: ☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

Neck: ☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

Back: ☐ Right mid back ☐ Left mid back ☐ Central mid back ☐ Right low back ☐ Left low back ☐ Central low back

Trunk: ☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs

Upper Extremity:	☐ Front of right upper extremity	☐ Rear of right upper extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shoulder	☐ Rear of left shoulder
	☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
	☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
	☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
	☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand
Lower Extremity	☐ Front of right lower extremity	☐ Rear of right lower extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
	☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
	☐ Front of right knee	☐ Rear of right knee	☐ Front of left knee	☐ Rear of left knee
	☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
	☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear of left ankle
	☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
	☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot
	☐ OTHER			

Does the discomfort radiate/travel? ○ Yes ○ No

Where does the pain radiate to? Choose all that apply; choose non-radiating if none apply.

☐ Non-radiating			
☐ Front of left chest	☐ Front of right chest	☐ Front of left abdomen/groin	☐ Front of right abdomen/groin
☐ Front of left thigh	☐ Front of left lower leg	☐ Radiating to top of left foot	☐ Front of left shoulder
☐ Front of left upper arm	☐ Front of left lower arm	☐ Front of left hand	☐ Front of left face
☐ Front of right thigh	☐ Front of right lower leg	☐ Radiating to top of right foot	☐ Front of right shoulder
☐ Front of right upper arm	☐ Front of right lower arm	☐ Front of right hand	☐ Front of right face
☐ Back of left thigh	☐ Back of left lower leg	☐ Bottom of left foot	☐ Back of left shoulder
☐ Back of left upper arm	☐ Back of left lower arm	☐ Back of left hand	☐ Back of left side of head
☐ Back of right thigh	☐ Back of right lower leg	☐ Bottom of right foot	☐ Back of right shoulder
☐ Back of right upper arm	☐ Back of right lower arm	☐ Back of right hand	☐ Back of right side of head

Describe the quality of the discomfort. Choose all that apply.

☐ Aching	☐ Annoying	☐ Burning	☐ Deep	☐ Diffuse	☐ Dull
☐ Heavy	☐ Intolerable	☐ Pulling	☐ Sharp	☐ Shock-like	☐ Shooting
☐ Stabbing	☐ Stiffness	☐ Throbbing	☐ Tightness	☐ Tingling	☐ OTHER

Complaint #4 Information (2):

Onset of discomfort: ○ Gradual ○ Insidious ○ Recent ○ Spontaneous ○ Sudden ○ Traumatic ○ Unknown

Intensity of discomfort: ○ Mild ○ Mild to moderate ○ Moderate ○ Moderate to severe ○ Severe

Severity of discomfort: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Frequency of discomfort: ○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring

How has severity of the complaint changed since the onset? ○ Improved ○ Stayed the same ○ Worsened

What activity is most significantly affected by this discomfort? _____

What improves this condition? Choose all that apply.

☐ Chiropractic adjustment ☐ Cold packs ☐ Exercise ☐ Heat packs ☐ Massage
☐ Nothing ☐ OTC medications ☐ Physical therapy ☐ Prescription medication ☐ Re-direct attention
☐ Rest ☐ Stretching ☐ Work ☐ OTHER

What treatment have you received for this condition up to now?

☐ None ☐ Acupuncture ☐ Chiropractic care ☐ Craniosacral therapy ☐ Homeopathic medicine
☐ Hypnosis ☐ Injection therapy ☐ Medical care ☐ Naturopathic medicine ☐ Nutritional supplements
☐ Occupational therapy ☐ Osteopathic medicine ☐ OTC medications ☐ Physical therapy ☐ Prescribed medications
☐ Psychotherapy ☐ Reiki ☐ Surgery ☐ OTHER

Were any diagnostic tests performed to assess this condition (including X-rays, MRIs, etc.)? ○ Yes ○ No ○ Unsure

Have you ever had any previous episodes of this condition? ○ Yes ○ No

In what ways does this condition affect your life and your ability to function? Choose all that apply.

☐ Bending over ☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing myself
☐ Driving a car ☐ Exercising ☐ Getting in/out of car ☐ Getting to sleep ☐ Grocery shopping
☐ Household chores ☐ Lifting objects ☐ Looking over shoulder ☐ Love life ☐ Lying down
☐ Reaching overhead ☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing
☐ Staying asleep ☐ Using a computer ☐ Walking ☐ Yardwork

Mechanism of Injury:

The injury was due to: _____ Date of accident: _____

FOR WORKMAN'S COMPENSATION-RELATED VISITS ONLY:

How did the injury occur? Choose all that apply.

- ☐ Bending
- ☐ Carrying
- ☐ Climbing
- ☐ Crawling
- ☐ Driving (driver)
- ☐ Driving (passenger)
- ☐ Job activity
- ☐ Jumping
- ☐ Kneeling
- ☐ Raising arm(s) above shoulder(s)
- ☐ Repetitive motion
- ☐ Running
- ☐ Sitting
- ☐ Squatting
- ☐ Standing
- ☐ Standing from a seated position
- ☐ Traveling (public transportation)
- ☐ Turning
- ☐ Twisting
- ☐ Typing
- ☐ Using computer
- ☐ Walking
- ☐ OTHER

FOR PEDESTRIAN ACCIDENTS ONLY:

As a pedestrian, what were you (or was the patient) doing at the time of the accident? _____

FOR AUTO ACCIDENTS ONLY:

Were you (or was the patient) wearing a seatbelt? ○ Yes ○ No ○ Don't know Did the airbag deploy? ○ Yes ○ No

Where in the vehicle were you (or was the patient) when the accident happened? _____

What interior vehicle part did you (or the patient) come into contact with? Choose all that apply.

- ☐ No interior parts were contacted at time of accident
- ☐ Airbag
- ☐ Armrest
- ☐ Dashboard
- ☐ Door
- ☐ Flying object(s) inside vehicle
- ☐ Headrest
- ☐ Seat
- ☐ Steering wheel
- ☐ Window
- ☐ Windshield

FOR MOTORCYCLE/BICYCLE ACCIDENTS ONLY:

Where on the vehichle were you (or was the patient) when the accident happened? ○ Operator ○ Passenger

What type of protection did you (or did the patient) have? Choose all that apply.

- ☐ Bicycle helmet
- ☐ Motorcycle Helmet- full face
- ☐ Motorcycle Helmet- open face
- ☐ Motorcycle Helmet- half helmet
- ☐ Protective eyewear
- ☐ Leathers
- ☐ Gloves
- ☐ Boots
- ☐ No protective wear
- ☐ OTHER

What did you (or the patient) come into contact with at the time of the collision? _____

Where were you (or was the patient) looking at the time of impact? _____

Did you (or the patient) come in contact with anything at the time of the collision? ○ Yes ○ No ○ Don't know

What part of your (or the patient's) body made contact? Choose all that apply.

- ☐ None made contact
- ☐ Back of head/neck
- ☐ Front of head
- ☐ Left arm
- ☐ Left chest/flank
- ☐ Left foot
- ☐ Left head
- ☐ Left knee
- ☐ Left leg
- ☐ Left shoulder
- ☐ Right arm
- ☐ Right chest/flank
- ☐ Right foot
- ☐ Right head
- ☐ Right knee
- ☐ Right leg
- ☐ Right shoulder
- ☐ OTHER

Did you (or the patient) receive an injury to the head? ○ Yes ○ No Did you (or the patient) lose consciousness? ○ Yes ○ No

What part of your (or the patient's) vehicle was impacted? Choose all that apply.

- ☐ Front right
- ☐ Front left
- ☐ Front head on
- ☐ Rear right
- ☐ Rear left
- ☐ Rear end
- ☐ Right side (passenger's side)
- ☐ Left side (driver's side)
- ☐ Unknown

In what direction was your (or the patient's) vehicle moving? _____

What was the estimated speed of your (or the patient's) vehicle? _____

What was the extent of the damage to your (or the patient's) vehicle? _____

What was the extent of the damage to the other vehicle? _____

In what direction was the other vehicle moving? _____

Mechanism of Injury (2):

What was the estimated speed of the other vehicle? _____

Was your (or the patient's) vehicle towed from the scene? ◯ Yes ◯ No Did police arrive at the scene? ◯ Yes ◯ No

Did Emergency Medical Services arrive at the scene? ◯ Yes ◯ No Was an accident report taken? ◯ Yes ◯ No

Were you (or was the patient) transported to a medical facility (ER or hospital)? _____

Have you (or has the patient) received any treatment since the accident? Choose all that apply.

- ☐ Admitted
- ☐ Examination was performed
- ☐ Home treatment with cold
- ☐ Home treatment with heat
- ☐ Home treatment with over-the-counter medication
- ☐ Home treatment with rest
- ☐ Medication was prescribed
- ☐ No treatment since accident
- ☐ Physical therapy
- ☐ Referred for further evaluation and treatment
- ☐ Referred to a chiropractor
- ☐ Referred to a neurologists
- ☐ Referred to orthopedists
- ☐ Referred to primary care provider
- ☐ Released
- ☐ Released that day
- ☐ Surgery
- ☐ X-rays were completed
- ☐ OTHER

What was the location of symptoms felt at the time of the accident? Choose all that apply.

Head: ☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

Neck: ☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

Back: ☐ Right mid back ☐ Left mid back ☐ Central mid back ☐ Right low back ☐ Left low back ☐ Central low back

Trunk: ☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs

Upper Extremity:	☐ Front of right upper extremity	☐ Rear of right upper extremity	☐ Front of left upper extremity	☐ Rear of left upper extremity
	☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shoulder	☐ Rear of left shoulder
	☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
	☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
	☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
	☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand
Lower Extremity:	☐ Front of right lower extremity	☐ Rear of right lower extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
	☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
	☐ Front of right knee	☐ Rear of right knee	☐ Front of left knee	☐ Rear of left knee
	☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
	☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear of left ankle
	☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
	☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot
	☐ OTHER			

Describe the discomfort felt at the time of the accident. Choose all that apply.

- ☐ Aching ☐ Burning ☐ Deep ☐ Diffuse ☐ Dull ☐ Heavy ☐ Numbness ☐ Pulling
- ☐ Sharp ☐ Shock like ☐ Shooting ☐ Stiffness ☐ Throbbing ☐ Tightness ☐ Tingling ☐ OTHER

Are there any additional symptoms which appeared since the accident happened? Choose all that apply.

- ☐ None ☐ Anxiety ☐ Breathing difficulty ☐ Chest pain ☐ Depression
- ☐ Disbelief ☐ Dizziness ☐ Exhaustion ☐ Facial pain ☐ Genital pain
- ☐ Gluteal pain ☐ Headaches ☐ Irritability ☐ Loss of appetite ☐ Low energy
- ☐ Muscle spasm ☐ Numbness and tingling ☐ Rib pain ☐ Shock ☐ Sleeping difficulty
- ☐ Soreness ☐ Stomach pain ☐ Stress ☐ Stunned ☐ Tightness
- ☐ Tiredness ☐ OTHER

Mechanism of Injury (3):

Describe the status of your symptoms since the accident. Choose all that apply.

- ☐ Deteriorated daily functioning at home/work
- ☐ Disappeared
- ☐ Elicited less stiffness
- ☐ Elicited more stiffness
- ☐ Elicited less pain
- ☐ Elicited more pain
- ☐ Exacerbated
- ☐ Improved
- ☐ Improved daily functioning at home/work
- ☐ Lessened
- ☐ Shown no change in daily functioning at home/work
- ☐ Somewhat resolved
- ☐ Stayed the same
- ☐ Worsened
- ☐ Worsened quality of life
- ☐ OTHER

Review of Systems:

Musculoskeletal - Other than the musculoskeletal complaints you mentioned already, do you have or have you ever had:

- ☐ No additional musculoskeletal complaints
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Scoliosis
- ☐ Joint or muscle pains/stiffness
- ☐ Cramping
- ☐ Swelling, redness deformity of joint(s)
- ☐ Fractures
- ☐ Implants, plates, pins or screws
- ☐ Neck pain
- ☐ Back problems
- ☐ Hip disorders
- ☐ Knee injuries
- ☐ Foot/ankle pain
- ☐ Shoulder problems
- ☐ Elbow/wrist pain
- ☐ Poor posture
- ☐ Gout

Neurological - Other than the neurological complaints you mentioned already, do you have or have you ever had:

- ☐ No additional neurological complaints
- ☐ Anxiety and/or panic
- ☐ Depression
- ☐ Memory issues
- ☐ Sleeping issues
- ☐ Headache
- ☐ Dizziness
- ☐ Weak muscles
- ☐ Pins and needles
- ☐ Numbness
- ☐ Loss of smell or taste
- ☐ Temporary loss of vision, smell or hearing
- ☐ Difficulty concentrating
- ☐ Stroke
- ☐ Epilepsy or seizures

Head, Eyes, Ears, Nose and Throat - Do you have or have you ever had:

- ☐ No complaints
- ☐ Headaches or migraines
- ☐ Eye or vision problems
- ☐ Eyeglasses or contact lenses
- ☐ Eye surgery
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Nose congestion or sinus trouble
- ☐ Ear or hearing problems
- ☐ Dental problems
- ☐ Gum problems
- ☐ TMJ problems
- ☐ Sore throat
- ☐ Postnasal drip
- ☐ Swollen lymph nodes
- ☐ OTHER

Cardiovascular - Do you have or have you ever had:

- ☐ No cardiovascular complaints
- ☐ Chest pain or tightness
- ☐ Palpitations
- ☐ Swollen legs or feet
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Congenital heart defects
- ☐ Rheumatic fever
- ☐ Leg pain upon walking
- ☐ Blood clots
- ☐ Varicose veins
- ☐ Dizziness
- ☐ Excessive bruising
- ☐ Coronary artery disease
- ☐ OTHER

Respiratory - Do you have or have you ever had:

- ☐ No respiratory complaints
- ☐ Persistent cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Snoring issues
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Blood in sputum
- ☐ Asthma
- ☐ Apnea
- ☐ Emphysema
- ☐ Hay fever
- ☐ OTHER

Gastrointestinal - Do you have or have you ever had:

- ☐ No gastrointestinal complaints
- ☐ Abdominal pain
- ☐ Nausea or vomiting
- ☐ Bloating
- ☐ Heartburn
- ☐ Ulcer
- ☐ Difficulty swallowing
- ☐ Jaundice
- ☐ Liver disease
- ☐ Gallbladder problems
- ☐ Pancreatitis
- ☐ Change in bowel habits
- ☐ Black or bloody stool
- ☐ Colon cancer or colon polyps
- ☐ Hemorrhoids
- ☐ Food sensitivities
- ☐ Constipation
- ☐ Severe diarrhea
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's disease
- ☐ Gastric reflux
- ☐ Collitis
- ☐ OTHER

Genitourinary - Do you have or have you ever had:

- ☐ No genitourinary complaints
- ☐ Painful or frequent urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Urinary infections
- ☐ Sexual dysfunction
- ☐ Incontinence
- ☐ OTHER

Review of Systems (2):

Endocrine - Do you have or have you ever had:

- ☐ No endocrine complaints
- ☐ Feeling hot or cold all the time
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Increase urination
- ☐ Excessive thirst
- ☐ Hyperthyroidism
- ☐ Hyperparathyroidism
- ☐ Testosterone deficiency
- ☐ Cushing's syndrome
- ☐ Steroid treatments
- ☐ OTHER

Dermatological and Bleeding - Do you have or have you ever had:

- ☐ No skin or bleeding complaints
- ☐ Skin trouble or rashes
- ☐ Flushing
- ☐ Change in hair or nails
- ☐ Excessive acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Skin pigmentation issues
- ☐ Blood in stool
- ☐ Easy bruising
- ☐ Gum bleeding
- ☐ OTHER

Past, Family and Social History:

List your (or the patient's) past surgical history. Choose all that apply and indicate the year in which the surgeries were performed.

- ☐ Yes, surgical history
- ☐ No surgical history
- ☐ Abdominal aortic aneurysm repair Year ____
- ☐ Appendectomy Year ____
- ☐ Biopsy Year ____
- ☐ Bunionectomy Year ____
- ☐ Cardiac bypass Year ____
- ☐ Cardiac valve replacement Year ____
- ☐ Carpal tunnel - left Year ____
- ☐ Carpal tunnel - right Year ____
- ☐ Cataract - left Year ____
- ☐ Cataract - right Year ____
- ☐ C-section Year ____
- ☐ Cosmetic - face lift Year ____
- ☐ Cosmetic - nose Year ____
- ☐ Cosmetic - breast reduction or enlargement Year ____
- ☐ Cosmetic - tummy tuck Year ____
- ☐ Cosmetic - other Year ____
- ☐ Ear tubes Year ____
- ☐ Gall bladder removed Year ____
- ☐ Gastric bypass Year ____
- ☐ Hysterectomy - complete Year ____
- ☐ Hysterectomy - partial Year ____
- ☐ Knee - left Year ____
- ☐ Knee - right Year ____
- ☐ Lasik Year ____
- ☐ Mastectomy Year ____
- ☐ Shoulder - left Year ____
- ☐ Shoulder - right Year ____
- ☐ Thyroidectomy Year ____
- ☐ Tonsils Year ____
- ☐ Tonsils & adenoids Year ____
- ☐ Wisdom teeth Year ____
- ☐ Discectomy level Year ____
- ☐ Implants Year ____
- ☐ Ganglion cyst Year ____
- ☐ Spinal fusion Year ____
- ☐ Transplant Year ____
- ☐ OTHER Year ____

Describe any past illnesses or conditions the doctor should be aware of and the age at which the illness(es) reportedly occurred.

☐ Yes, past illnesses ☐ No past illnesses (including diabetes, cancer, hypertension and progressive neurological diseases)

Number of children ____ Number of pregnancies ____ Number of deliveries ____

- ☐ AIDS/HIV Age ____
- ☐ Alcoholism Age ____
- ☐ Alzheimer's Age ____
- ☐ Anemia Age ____
- ☐ Anorexia Age ____
- ☐ Arthritis Age ____
- ☐ Asthma Age ____
- ☐ Bleeding disorders Age ____
- ☐ Breast lump Age ____
- ☐ Bronchitis Age ____
- ☐ Bulimia Age ____
- ☐ Cancer Age ____ Explain _____
- ☐ Chemical dependency Age ____
- ☐ Congenital anomaly Age ____ Explain _____
- ☐ Depression Age ____
- ☐ Diabetes Age ____
- ☐ Emphysema Age ____

Past, Family and Social History (2):

☐ Epilepsy	Age	_____		
☐ Extremity issues	Age	_____	Explain	_____
☐ Fracture	Age	_____	Explain	_____
☐ Heart disease	Age	_____		
☐ Hepatitis	Age	_____		
☐ Hereditary disorder	Age	_____	Explain	_____
☐ Hernia	Age	_____		
☐ Herniated disc	Age	_____		
☐ High blood pressure	Age	_____		
☐ High cholesterol	Age	_____		
☐ Hospitalization	Age	_____	Explain	_____
☐ Kidney disease	Age	_____		
☐ Liver disease	Age	_____		
☐ Migraine headaches	Age	_____		
☐ Miscarriage	Age	_____		
☐ Multiple sclerosis	Age	_____		
☐ Natural labor	Age	_____		
☐ Neuromuscular issues	Age	_____	Explain	_____
☐ Osteoarthritis	Age	_____		
☐ Osteoporosis	Age	_____		
☐ Pacemaker	Age	_____		
☐ Parkinson's disease	Age	_____		
☐ Pinched nerve	Age	_____		
☐ Pneumonia	Age	_____		
☐ Polio	Age	_____		
☐ Previous chiropractic care	Age	_____		
☐ Prostate problems	Age	_____		
☐ Psychiatric care	Age	_____		
☐ Rheumatoid arthritis	Age	_____		
☐ Stroke	Age	_____		
☐ Suicide attempt	Age	_____		
☐ Thyroid problems	Age	_____		
☐ Trauma/injury	Age	_____	Explain	_____
☐ Tumor	Age	_____		
☐ Ulcers	Age	_____		
☐ Vaginal infection	Age	_____		
☐ Venereal disease	Age	_____		
☐ OTHER	Age	_____		

Past, Family and Social History (3):

List any past history of accidents or trauma. Choose all that apply.

- [ ] No previous trauma reported
- [ ] No new trauma reported since initial intake
- [ ] Single automobile accident
- [ ] Multiple automobile accidents
- [ ] Slip and fall
- [ ] Multiple slip and falls
- [ ] Single motorcycle accident
- [ ] Multiple motorcycles accident
- [ ] Single boating accident
- [ ] Multiple boating accidents
- [ ] Resulting in fracture(s)
- [ ] Resulting in permanent injury or disability
- [ ] Resulting in hospitalization(s)
- [ ] Resulting in no significant injury or loss
- [ ] Resulting in sprains/strains
- [ ] Resulting in loss of consciousness
- [ ] Suicide (including attempts)
- [ ] OTHER

Are you presently taking any medication? ○ Yes ○ No

Which of the following medications are you presently taking? Choose all that apply.

- [ ] Over-the-counter
- [ ] Prescription
- [ ] Antidepressant
- [ ] Muscle relaxer
- [ ] Anti-inflammatory (NSAID)
- [ ] Steroidal Anti-inflammatory
- [ ] Antacid
- [ ] Anti-viral
- [ ] Aspirin
- [ ] Chemotherapy
- [ ] Codeine
- [ ] Hallucinogenic
- [ ] Marijuana
- [ ] Mood elevator
- [ ] Sleeping pill
- [ ] Stimulant
- [ ] Tranquilizer
- [ ] OTHER

List your (or the patient's) family health history. Choose all that apply to blood relatives only.

- [ ] No family history of diabetes, cancer, hypertension and progressive neurological disorders.
- [ ] Not applicable, patient was adopted
- [ ] No change in family health history
- [ ] Unknown
- [ ] AIDS/HIV
- [ ] Alcoholism
- [ ] Alzheimer's
- [ ] Anemia
- [ ] Anorexia
- [ ] Arthritis
- [ ] Asthma
- [ ] Bleeding disorders
- [ ] Breast lump
- [ ] Bronchitis
- [ ] Bulimia
- [ ] Cancer
- [ ] Chemical dependency
- [ ] Congenital anomaly
- [ ] Depression
- [ ] Diabetes
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Extremity issues
- [ ] Fracture
- [ ] Heart disease
- [ ] Hepatitis
- [ ] Hereditary disorder
- [ ] Hernia
- [ ] Herniated disc
- [ ] High blood pressure
- [ ] High cholesterol
- [ ] Hospitalization
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Migraine headaches
- [ ] Miscarriage
- [ ] Multiple sclerosis
- [ ] Natural labor
- [ ] Neuromuscular issues
- [ ] Osteoarthritis
- [ ] Trauma/injury
- [ ] OTHER

What are your (or are the patient's) current work habits? Choose all that apply.

- [ ] No change in work habits since condition began
- [ ] Cannot not work due to presenting condition
- [ ] None reported
- [ ] Permanently fully disabled
- [ ] Permanently partially disabled
- [ ] 0 to 20 hours per week
- [ ] 20 to 40 hours per week
- [ ] 40 to 50 hours per week
- [ ] 50 to 60 hours per week
- [ ] 60 to 70 hours per week
- [ ] Over 70 hours per week
- [ ] Full-time
- [ ] Part-time
- [ ] Homemaker
- [ ] Retired
- [ ] Student
- [ ] Unemployed
- [ ] Mostly sitting
- [ ] Mostly standing
- [ ] Mostly walking
- [ ] Light labor
- [ ] Moderate labor
- [ ] Heavy labor
- [ ] Sedentary
- [ ] Computer
- [ ] Repetitive
- [ ] Telephone
- [ ] Difficult
- [ ] Enjoyable
- [ ] Relaxed
- [ ] Stressful

Past, Family and Social History (4):

How would you describe your (or the patient's) personal social habits? Choose all that apply.

- ☐ No change in social habits since injury
- ☐ Does not smoke, drink alcohol or take recreational drugs
- ☐ A social drinker
- ☐ A light drinker
- ☐ A moderate drinker
- ☐ A heavy drinker
- ☐ An alcoholic
- ☐ A recovering alcoholic
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Ex-smoker
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker
- ☐ Never smoked tobacco
- ☐ Smoker, current status unknown
- ☐ Unknown if ever smoked
- ☐ Does not drink caffeine
- ☐ Drinks 1 cup of caffeine in the morning
- ☐ Drinks 2 to 4 cups of caffeine per day
- ☐ Drinks 5 or more cups of caffeine per day
- ☐ Does not use recreational drugs
- ☐ Light use of recreational drugs
- ☐ Moderate use of recreational drugs
- ☐ Heavy use of recreational drugs
- ☐ Is drug addicted
- ☐ Is a recovering drug addict

How would you describe your (or the patient's) present exercise habits? Choose all that apply.

- ☐ No changes in exercise habits since condition began
- ☐ Daily
- ☐ None
- ☐ Every other day
- ☐ Few times a week
- ☐ Once a week
- ☐ Almost nothing
- ☐ Aerobic
- ☐ Stretching
- ☐ Strength
- ☐ Baseball
- ☐ Basketball
- ☐ Blading
- ☐ Boating
- ☐ Climbing
- ☐ Cycling
- ☐ Football
- ☐ Golf
- ☐ Handball
- ☐ Hang gliding
- ☐ Hiking
- ☐ Ice skating
- ☐ Mountain climbing
- ☐ Ping-Pong
- ☐ Racquetball
- ☐ Running
- ☐ Skiing
- ☐ Skydiving
- ☐ Snowboarding
- ☐ Soccer
- ☐ Surfing
- ☐ Tennis
- ☐ Volleyball
- ☐ Walking
- ☐ Waterskiing
- ☐ Weight training
- ☐ Weight training with a personal trainer
- ☐ Pilates
- ☐ Spinning
- ☐ Step
- ☐ Yoga
- ☐ Zumba

How would you describe your (or the patient's) diet and nutritional status? Choose all that apply.

- ☐ No changes in diet or nutrition since condition began
- ☐ Controlled
- ☐ Out-of-control
- ☐ Restricted
- ☐ Unrestricted
- ☐ 1 to 2 meals a day
- ☐ 2 to 3 meals a day
- ☐ More than 3 meals a day
- ☐ Reports eating too little
- ☐ Reports eating too much
- ☐ Binges
- ☐ Purges
- ☐ Balanced
- ☐ High protein
- ☐ Low carbohydrate
- ☐ Low-fat
- ☐ Low-cholesterol
- ☐ No red meat
- ☐ Atkins
- ☐ Diabetic
- ☐ Gluten free
- ☐ Ideal Protein
- ☐ Jenny Craig
- ☐ Kosher
- ☐ Macrobiotic
- ☐ Paleo
- ☐ Raw food
- ☐ South Beach
- ☐ Vegan
- ☐ Vegetarian
- ☐ Weight Watchers
- ☐ Zone
- ☐ Does not take daily supplements
- ☐ Takes daily supplements
- ☐ OTHER

Employer Information:

Employed: _____ Employer Name _____

Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Supervisor: _____ Supervisor #: _____

Work Duties: _____

Insurance Information:

Payment Name		Primary Phone #		Primary ID/Policy	
Payment Address					
Payment City		Payment State		Payment Zip	
Primary Group #		Primary Name		Primary DOB	
Secondary Name		Secondary Phone #		Secondary ID/Policy	
Secondary Address					
Secondary City		Secondary State		Secondary Zip	
Secondary Group #		Secondary Name		Secondary DOB	
Claim #		Claim Contact		Claim #	
Attorney Name		Attorney Phone #			

Personal Health History

Last Physical Exam:		Primary Phys:		Phys Phone #:	
Phys City:		Phys State:		Phys Zip:	
Health Conditions:					
Previous Chiro Care: ◯ Yes ◯ No		Date:		Condition(s) treated:	
Chance Pregnant: ◯ Yes ◯ No		Planning: ◯ Yes ◯ No			
Medications:					
Supplements:					

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature _____ Date: _____