Dr. Susie Warden D.C.
411 E. Roosevelt Rd..
Wheaton, IL 60187
630-260-1300

ADVANCED HEALTHCARE CENTER

Full Name:_____ Today's Date_____

S.S.# _____ Address _____

City _____ State: _____ Zip _____ Home Phone _____

Cell Phone_____ Work Phone_____

E-Mail address_____ Birth Date_____ Age_____

Where Employed _____ Occupation _____
Height _____ Weight _____ Race _____
Spouse Name _____ Primary Care Physician_____
Practice Location: _____

**An understanding of your health history will help us to determine appropriate care**

I. Please describe your current complaint. In other words, what brought you to our clinic?
_____
_____

II. Did the pain begin after an accident or injury? _____

III. Approximately when did the pain begin? _____

IV. On a scale from 0 to 10, with 0 being the least intense, 10 being the most intense, on what level would you rate your pain when it is at its worst? _____

V. How would you describe the quality of the pain? _____

VI. What helps you with the pain? _____

VII. What makes the pain worse? _____

VIII. Are there any associated symptoms with your current complaint that you are aware of? _____

IX. What aspect of your daily activities does your pain interfere with the most?
_____
_____

X. Is there a previous history of this complaint before? Yes/No If yes, please describe_____
_____

**Review of Systems:**

1. Do you have skin, hair, or nail problems? Yes/No _____
2. Do you have mouth and/or throat problems? Yes/No_____
3. Do you have nose and/or sinus problems? Yes/No_____
4. Do you have ear problems? Yes/No_____
5. Do you have eye problems? Yes/No_____
6. Do you have chest or lung (breathing problems)? Yes/No_____
7. Do you smoke? Yes/No Cigarettes per day_____ How Long? _____
8. Do you have heart and/or blood vessel problems? Yes/No _____
9. Do you have blood or lymph node problems? Yes/No_____
10. Do you have digestive problems? Yes/No_____
11. Do you have genital problems (e.g. prostate, testicular, vaginal)? Yes/No_____
12. Do you have urinary, bladder, or kidney problems? Yes/No_____

13. **FEMALES** – Have you had menstrual problems? Yes/No_____
    Have you ever taken birth control pills? Yes/No For how long? _____
    Is there any chance that you care currently pregnant? Yes/No_____
    Do you have any breast problems? Yes/No _____
14. Do you have any nervous system diseases and/or mental health problems? Yes/No
    _____
15. Do you have any gland and/or hormone problems? Yes/No_____
16. Do you have allergy or immunity problems? Yes/No_____
17. Do you have any muscle, tendon, or ligament problems? Yes/No_____
18. Do you have any bone or joint diseases? Yes/No_____

**Past History:**

19. List any diseases that you have had in the past, including childhood diseases:
    _____
    _____
20. Tell us if you have ever been diagnosed as having a particular condition, such as diabetes, cancer, AIDS, etc: _____

21. Have you suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? Yes/No If yes, describe accident including date of accident
    _____
    _____
22. List any surgeries you have had:
    _____Date:_____
    _____Date:_____
    _____Date:_____
    _____Date:_____
23. Have you ever been hospitalized for any reason other than surgery?
    Yes/No_____
24. Please list all medications that you are currently taking or take on an occasional basis:
    _____

25. Have you ever had cancer? Yes/No If yes describe? _____

**Family History:**

26. Are there any diseases or conditions that are common among your family members? Yes/No_____

**Social History:**

27. In what position do you usually sleep? _____
28. Do you exercise on a regular basis? Yes/No activities? _____
29. Your diet is: ☐ Balanced ☐ Fair ☐ Poor ☐ Excessive ☐ Restricted
30. Do you use: ☐ Caffeine ☐ Tobacco ☐ Nicotine ☐ Recreational Drugs ☐ Alcohol

31. Please describe your work:

Type: ☐ Professional ☐ Physical Labor ☐ Driver ☐ Clerical ☐ Factory ☐ Homemaker

Physical Demands: ☐ Heavy ☐ Moderate ☐ Mild ☐ Sedentary

Stress Level: ☐ High ☐ Medium ☐ Low

**Additional History**

32. If there is any information about your health history that was not requested, please fill in below_____
33. Have you ever seen a Chiropractor before? Yes/No If yes how long ago? _____
34. Have you ever seen a physical therapist before? Yes/No If yes how long ago?_____
35. What are you hoping to achieve from care in our office (please check all that apply)

☐ relief care ☐ corrective care ☐ wellness/preventative care