Please insert a number after each problem listed which will designate if it is current or past.

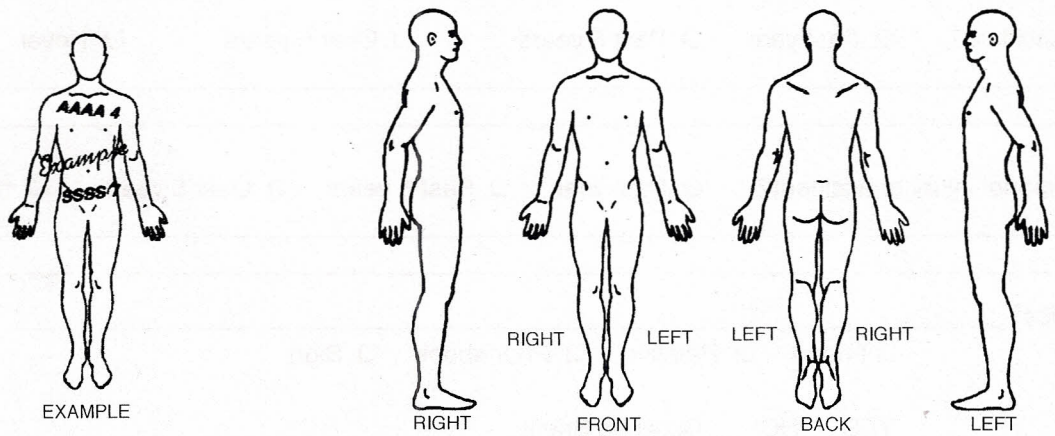
1. Having Now 2. Comes and goes 3. Had in the past

Headaches_____
Shooting head pains_____
Pins and needles in arms / hands_____
Head feels too heavy_____
Loss of balance_____
Dizziness_____
Grating noise in the neck_____
Ringing in the ears_____
Shoulder Pain_____
Tightness of shoulder muscles_____
Neck pain_____
Pain between shoulder blades_____
Low back pain_____
Pains in legs and feet_____
Slipped disc_____
Pinched nerve in back_____
Pins and needles in legs_____
Cold feet_____
Long term back trouble_____
Pain in joints_____
Arthritis_____
Cold hands_____
Chest pains_____
Shortness of breath_____

Fainting_____
Sinus trouble_____
Asthma_____
Allergies_____
Seizures_____
Heart attacks_____
High blood pressure_____
Diabetes_____
Cancer_____
Stroke_____
HIV_____
Ulcers_____
Indigestion_____
Constipation_____
Liver Trouble_____
Gall Bladder trouble_____
Kidney trouble_____
Bladder trouble_____
Menstrual irregularity_____
Fatigue_____
Depression_____
Inner tension_____
Irritability_____
Sleeping problems_____

Please mark your area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

DESCRIPTION →	NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
SYMBOL →	NNNN	PPPP	BBBB	AAAA	SSSS



Do you have any health insurance? Yes____ No___ Name of insurance_____

Are you interested in a nutritional evaluation? Yes____ No___

Patient Signature_____ **Date**_____

DOCTOR'S NOTES

LAKELAND CHIROPRACTIC

CONFIDENTIAL INFORMATION

Date_____

Please Print

Name_____Phone: Cell(____)_____Home(____)_____

Street_____City_____Zip_____

Age_____ Birthdate_____/_____/_____ Marital: M S W D How many Children?_____

Occupation_____Employer_____

Primary Complaints_____ Other Complaints_____

First Noticed_____ Cause of Problem_____

This condition is aggravated by:

❑ Working ❑ Sitting ❑ Sleeping ❑ Standing ❑ Sneezing

❑ Excercising ❑ Lifting ❑ Walking ❑ Bending ❑ Coughing

Have you had this problem before? ❑ Yes ❑ No If Yes, when?_____

List M.D.'s or Chiropractors seen for this condition now or in the past_____

Have you had chiropractic care before? ❑ Yes ❑ No If yes, name of Chiropractor_____

Address: City_____ State_____ Date of Adjustment_____ Date of last x-ray_____

Do you Smoke? ❑ NO ❑ YES _____ packs/day

Are you Pregnant? ❑ NO ❑ YES ❑ NOT SURE Are you Nursing? ❑ NO ❑ YES

Medication you now take:

❑ Pain Killers ❑ Muscle Relaxers ❑ Stimulants ❑ Tranquilizers ❑ Insulin ❑ Birth Control

❑ Vitamins Others:_____

Are you wearing: ❑ Heel Lifts ❑ Sole Lifts ❑ Inner Soles ❑ Arch Supports

Have you been in an auto accident? ❑ Past year ❑ Past 5 years ❑ Over 5 years ❑ Never

Describe_____

_____

Have you had any other personal injury or accident? ❑ Past year ❑ Past 5 years ❑ Over 5 years ❑ Never

Describe_____

_____

Who referred you to our office?_____

❑ Friend ❑ Relative ❑ Phonebook ❑ Sign

HAVE YOU EVER:	YES	NO	Describe Briefly
Been knocked unconscious?	❑	❑	
Had a MRI or CT Scan?	❑	❑	
Been treated for a spine or nerve disorder?	❑	❑	
Had a fractured bone?	❑	❑	
Had any surgery?	❑	❑	
Been hospitalized for other than surgery?	❑	❑	
Been treated for any major illness or disease as a child or adult?	❑	❑	

Is this a workers compensation claim? ❑ YES ❑ NO Date of Injury_____

Is this an auto accident claim? ❑ YES ❑ NO Date of Accident_____

(OVER)