Name:_____ Date of Birth:_____

Date of Last:
Last Chiropractic Visit_____
Primary Care Physician Exam: _____ X-Ray/MRI/CT Bone Scan: _____
Blood Test:_____ History of Immunosupressive Disorder: yes / no
History of Bleeding Disorders yes / no History of Cancer yes / no
History of Epilepsy yes / no Are you currently pregnant? yes / no
Smoking Status O Never O Former O Social/Daily

List all prescription, non-prescription medications and other supplements you take, *if none, please indicate*:

MEDICATION	STRENGTH/ FREQUENCY	MEDICATION	STRENGTH/ FREQUENCY	VITAMINS/HERBS/MINERALS	STRENGTH/ FREQUENCY

ALLERGIES:_____

Describe the reason(s) for your doctor visit today (include area(s) of pain): _____

_____

Is this directly related to an accident of work injury? yes / no If yes, please list injury date. _____
Complaint 1: _____
Pain Level: 0-10 (0= None; 10= Unbearable): Current ____ Average ____ Worst _____ Best _____

Complaint 2: _____
Pain Level: 0-10 (0= None; 10= Unbearable): Current ____ Average ____ Worst _____ Best _____

Complaint 3: _____
Pain Level: 0-10 (0= None; 10= Unbearable): Current ____ Average ____ Worst _____ Best _____

When did your symptoms start? _____How did your symptoms begin? _____

Have you experienced these symptoms in the past?_____

Have you seen another doctor for these symptoms? yes / no If yes, indicate name and type of medical provider:

_____

What activities does your pain interfere with? _____

Have you had any diagnostic testing (MRI, Xray, labwork) for your complaints? Yes / no If yes, please forward copy to our office.

What activities make it feel worse:_____

What activities make it feel better:_____

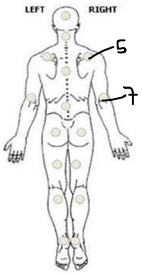
Please list your goals or expectations you have:_____

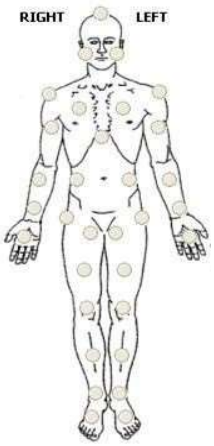
Additional comments you would like the doctor to know: _____

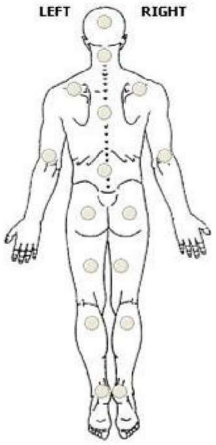
Name: _____ DOB: _____

Please grade pain, 0-10 (10 is the highest).

This is an example:







This complaint came on	O Gradually	O Suddenly	
It is getting:	O Better	O Same	O Worse
The intensity of this complaint is:	O Minimal	O Moderate	O Severe
The frequency of this complaint is:	O Occasional	O Frequent	O Constant
The pain is:	O Dull	O Sharp	O Aching
	O Shooting	O Spasm	O Throbbing
	O Burning	O Tingling	
The pain is located on the:	O Left	O Right	O Both sides
Actions affecting this complaint			
Morning	O Brings On	O Aggravates	O Relieves
Afternoon	O Brings On	O Aggravates	O Relieves
Bending forward	O Brings On	O Aggravates	O Relieves
Bending back	O Brings On	O Aggravates	O Relieves
Turning left	O Brings On	O Aggravates	O Relieves
Turning Right	O Brings On	O Aggravates	O Relieves
Coughing	O Brings On	O Aggravates	O Relieves
Sneezing	O Brings On	O Aggravates	O Relieves
Straining	O Brings On	O Aggravates	O Relieves
Standing	O Brings On	O Aggravates	O Relieves
Lifting	O Brings On	O Aggravates	O Relieves
Sitting/Deskwork/Computer Work	O Brings On	O Aggravates	O Relieves
Heat	O Brings On	O Aggravates	O Relieves
Cold	O Brings On	O Aggravates	O Relieves
Resting	O Brings On	O Aggravates	O Relieves
Lying Down/Sleeping	O Brings On	O Aggravates	O Relieves
Medication	O Brings On	O Aggravates	O Relieves
Exercise/Sports/Running	O Brings On	O Aggravates	O Relieves
House Chores	O Brings On	O Aggravates	O Relieves
Nighttime	O Brings On	O Aggravates	O Relieves

Signature: _____ ***Date***: _____

Office Use ONLY

BP (mmHg)_____/_____ Height(in)_____ Weight(lbs)_____ Pulse _____ O2 _____ Temp_____Examiner _____