

CONFIDENTIAL PATIENT INFORMATION

Purpose of this appointment (major concern) _____

Next top concerns _____

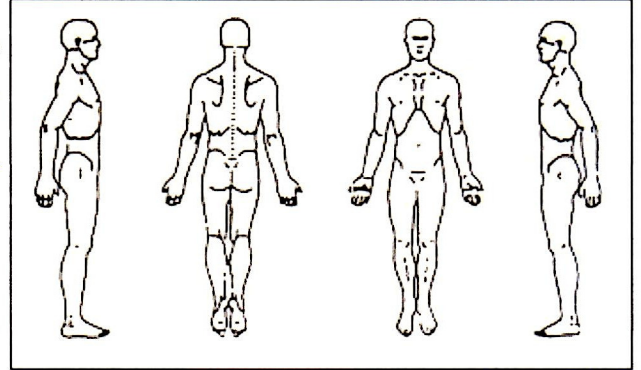
Is the condition due to injury or sickness arising out of patient's employment? _____ Date of onset _____ Sudden Gradual
 For patients dealing with Pain.

1. How bad is your pain or ache? Please circle a number: (0 is no pain, 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

2. Describe your pain or complaint:

- Dull Sharp Ache Stabbing
 Deep Superficial Spasm/Tension Numbness
 Tingling Burning Other _____

Show on the drawings below where your problem is located



3. Radiation: Does the pain travel to other parts of your body? Yes No
 Where? _____

4. Frequency: Occasional Intermittent Constant

5. Duration: How long does the pain last? _____

6. What makes the pain/problem worse?

- Standing Sitting Bending Twisting
 Walking Lifting Sleeping Heat
 Cold Stooping Sex
 Other _____

7. What makes the pain/problem better?

- Standing Sitting Rest Heat
 Cold Aspirin/Med Other _____

8. Other problems related to your main complaint _____

9. What treatment have you received for this condition? _____

10. Have you lost any days from work? _____

11. What do you believe is wrong with you? _____

12. What operations have you had? _____

13. Do you have any scars? _____ Do you have any mouth sores or tooth pain? _____

14. What medications or drugs are you taking? _____

15. Have you ever been under chiropractic care? Yes No Doctor's Name _____

Remarks and additional information _____

Have you ever suffered from: (read from top to bottom as a list)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Poor posture | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Spinal Curvatures | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Bed-wetting |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Colon trouble | <input type="checkbox"/> Sinus infection | <input type="checkbox"/> Kidney Infection or stones |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Prostrate trouble |
| <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Difficult digestion | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Cramps or backache |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pain over heart | <input type="checkbox"/> Excessive menstrual flow |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Nausea | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rapid heartbeat | <input type="checkbox"/> Irregular cycle |
| <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Colds | <input type="checkbox"/> Slow heartbeat | <input type="checkbox"/> Lumps in breasts |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Deafness | <input type="checkbox"/> Anemia | <input type="checkbox"/> Alcoholism |
| Tingling or numbness in: | <input type="checkbox"/> Ear noises | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Swelling of ankles |
| <input type="checkbox"/> Elbows | <input type="checkbox"/> Failing vision | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hands | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Spitting | <input type="checkbox"/> Hiatal Hernia |

Habits:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____

Are you currently taking vitamins or minerals? Yes No
 Do you think you may need to take vitamins and minerals? Yes No
 Are you wearing: Heel lifts Sole lifts Inner soles Arch supports

Date _____ Patient's Signature _____