Patient Name:______________________ DOB: ____________ Date: ____________ File #: ____________

CURRENT PROBLEM

Have you had previous chiropractic care? [ ] Yes [ ] No If yes, date of last care ____________

Seen by whom? ____________________

Have you had previous physical therapy? [ ] Yes [ ] No If yes, date of last care ____________

Where? ____________________

Have you seen any other doctors about this condition? [ ] Yes [ ] No If yes, name ____________

Were x-rays taken? [ ] Yes [ ] No Where?____________ Approx. date of x-rays ____________

What did the doctor say your problem was? ____________________

What treatment, if any, did you receive? ____________________

Have you done anything to cause this to happen? [ ] Yes [ ] No If so, what? ____________

How long has it been this bad? ____________________

Has this area been a problem before? [ ] Yes [ ] No

If so, how often? [ ] constantly [ ] frequently [ ] occasionally

For how long? ____________ When was the last time? ____________

Are you presently able to work? [ ] Yes [ ] No

Is this condition getting progressively worse? [ ] Yes [ ] No

PERSONAL HISTORY:

Please list any surgeries, their dates; fractures / dislocations, particularly those relating to the spine:

____

____

Have you ever had spinal x-rays, MRI, CT Scan, Bone Scan, etc.? [ ] Yes [ ] No

If yes regarding which condition? ____________________

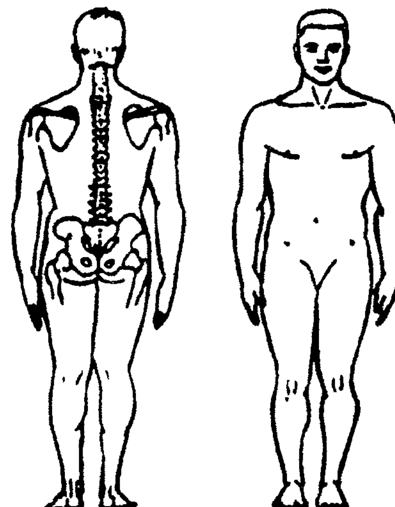
MAJOR COMPLAINT

Check the following areas which pertain to your complaint:

- ☐ Headaches
- ☐ Neck Pain
- ☐ Shoulder / Arm Pain
- ☐ Numbness Arm / Legs
- ☐ Mid Back Pain (Ribs)
- ☐ Chest Pain
- ☐ Low Back Pain
- ☐ Hip / Leg Pain
- ☐ Knee / Ankle Pain
- ☐ Other

PAIN DRAWING

Mark areas of pain on figures below:



FOR WOMEN ONLY

Is it possible you are pregnant? ☐ Yes ☐ No

Date of last menstrual period ____________