Today's Date (MM/DD/YYYY)

Your First Name **Your Middle Name (Or Initial)**

Your Last Name

Address

Marital Status
(•) Single ( ) Married
( ) Divorced
( ) Widowed ( ) Separated

City **State** **ZIP/Postal Code** **Date of Birth (MM/DD/YYYY)**

Number of Children _____ **Spouses Name**_____ **Height** ___'___" **Weight** _____**lbs** **Gender:** (•) **M** / ( ) **F**

Mobile phone_____ **Work phone**_____ **Occupation**_____

E-Mail Address

Emergency Contact **Phone** **Relation to you**

Referring Physician_____

Whom may we thank for referring you? _____ **How did you hear about us?** ✔ **Word of mouth** / ✔ **Social media** / ✔ **Internet**

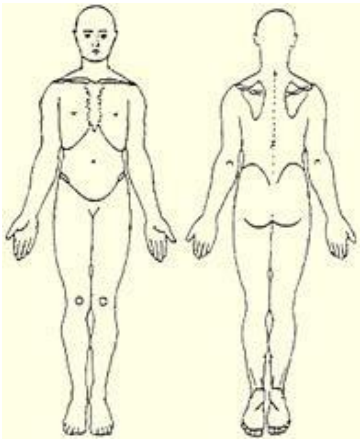
MAIN reason for visit: _____

Other Concerns: _____

Approximate date condition began: _____/_____/_____

What caused the condition:_____

On the body diagram, please indicate your areas of complaint with "X"



Which terms best describe your discomfort:

- (•) **Deep**
- ( ) **Dull**
- ( ) **Intolerable**
- ( ) **Sharp**
- ( ) **Shooting**
- ( ) **Stiffness**
- ( ) **Stabbing/throbbing**
- ( ) **Tight**
- ( ) **Tingling**

On a scale of 1 to 10, how would you rate your current level of pain?
(no pain) (•) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **(severe pain)**

How often do you feel this discomfort? ☐ **Constant** ☐ **Frequent** ☐ **Occasional** ✔ **Intermittent**

How has your complaint changed since it started? ☐ **Improved** ☐ **Stayed same** ✔ **Worsened**

CONFIDENTIAL HEALTH INFORMATION

What treatment have you received for your condition? ___none ___chiropractic ___massage ___medical ___ surgery____
___over the counter meds ___prescription meds ___acupuncture ___physical therapy Other:_____

What aggravates this condition? movement / athletic activity / bending / lifting / changing position / coughing / sneezing / child care / getting out of bed / household chores / turning head / lying down-sleeping / sitting / squatting standing / stress / walking-running / working at a desk / yardwork / Other:_____

What improves this condition? nothing / acupuncture / chiropractic / prescriptions / cold pack / exercise / rest / heat / stretching / massage / work / over-the-counter meds / physical therapy / Other:_____

Have other healthcare providers preformed tests related to this condition? YES / NO
◉ ○

Have you had any previous episodes of this condition? Yes / No
◉ ○

CURRENT HEALTH

Other than the information already provided, do you have additional concerns involving any of the following?

___Muscles, bones, joints Explain:_____
___Nerves, Headaches, Dizziness Explain:_____
___Head, Eyes, Ears, Nose, Throat Explain:_____
___Heart, Blood Press, Circulation Explain:_____
___Shortness breath, cough, asthma Explain:_____
___Stomach, Bowel, Digestive Explain:_____
___Diabetes, Thyroid, Glandular Explain:_____
___Skin or Bleeding problems Explain:_____
___Allergies or Sensitivities Explain:_____

What surgeries have you had? ___None if yes, explain_____
_____

Any past illnesses or conditions we need to be aware of? _____

What medications are your currently taking? ✔___None or _____
_____

Do you have a past family illness of : ___diabetes ___cancer (type_____) ___stroke ___high blood pressure
___Other_____

Work and Social Habits

Current Work Habits: ___permanently fully disabled ___permanently partially disabled ___can't work due to current condition
___working full-time ___working part time ___retired ___student ___homemaker ___unemployed

Personal/Social habits: ___smoke/tobacco use ___alcohol ___caffeine ___recreational drugs

Exercise Habits: ___none ___daily ___3x per week ___can't exercise due to current condition

Diet and Nutritional: ___vegan/vegetarian ___take daily supplements

WOMEN ONLY

Are you pregnant? ☐ Yes ☐ NO

Are you Nursing? ☑ Yes ☐ NO

Do you experience painful periods? ☑ Yes ☐ NO

Do you have irregular cycles? ☑ Yes ☐ NO

Do you have breast implants? ☐ Yes ☐ NO

Do you perform a regular self-breast exam? ☑ Yes ☐ NO

Do you take Hormone replacement? ☑ Yes ☐ NO

Do you take oral contraceptives? ☑ Yes ☐ NO

When was your last PAP/pelvic exam? ☐ within past year ☐ 1-4 years ☐ More than 5 years ☑ Never had

When was your last mammogram? ☑ within past year ☐ 1-4 years ☐ More than 5 years ☐ Never had

Date of last menstrual cycle? ☑ within last month ☐ within past 1-3 months ☐ greater than 3 months
(if still menstruating)