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Referred By____________________

NAME ________________________________ PREFERS ________________ DOB______________

PHONE ____________________ EMAIL ____________________ EMPLOYER ____________________

Please List Problems in Order of Their Severity

CONDITION 1

Describe your symptoms ____

____

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When did your symptoms start? ______________ What caused them? ______________

How does it feel? (ache, sharp, burn, etc.)______________What makes you feel worse? ______________

What makes you feel better? ______________Does the pain travel or spread? ______ , If so, where? ______________

Do you have any numbness? ________ How much of the day do you experience symptoms? 0-25% ❐ 26-50% ❐ 51-75% ❐ 76-100% ❐

Have you had similar problems in the past? ______________

Have you seen any other physicians for this condition? ______________

What activities do you do that are currently difficult, that you would like to perform better? ______________

Is there anything else you would like to mention or discuss? ______________

CONDITION 2

Describe your symptoms ____

____

____

When did your symptoms start? ______________ What caused them? ______________

How does it feel? (ache, sharp, burn, etc.)______________What makes you feel worse? ______________

What makes you feel better? ______________Does the pain travel or spread? ______ , If so, where? ______________

Do you have any numbness? ________ How much of the day do you experience symptoms? 0-25% 26-50% 51-75% 76-100%

Have you had similar problems in the past? ______________

Have you seen any other physicians for this condition? ______________

What activities do you do that are currently difficult, that you would like to perform better? ______________

Is there anything else you would like to mention or discuss? ______________

How would you rate your stress levels? (0= no stress, 10= high stress) ______ Do you exercise? _____ How Often? _____ What Activity? ______________

Do you take vitamins/supplements? _______ If so, what kind ______________

Are you currently under another physicians care? _______ If so, for what? ______________

Are you currently taking any medications? ________ If so, what kind? ______________

Please list any surgeries you've had ______________

Please list any history of significant illness in your family ______________

Have you ever been treated by a chiropractor before? __________When? ______________

Please list any accidents or traumas you've had ______________

Do you have a Pace Maker or any other heart condition? ______________