



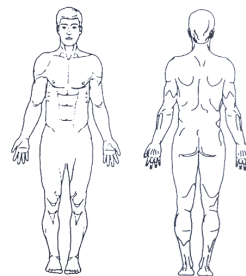
Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age (\_\_\_\_)  
 Referred by \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Marital Status  Single  Married  Divorced  Widowed Spouse's Name \_\_\_\_\_  
 Spouse's Occupation \_\_\_\_\_ Number of Children & Ages \_\_\_\_\_  
 Have you ever received Chiropractic Care?  Yes  No If yes, when, where, & why? \_\_\_\_\_  
 Social Security # \_\_\_\_\_ E-Mail Address \_\_\_\_\_

## Symptoms and Ill Health (Present State)

Major Complaint \_\_\_\_\_  
 Pain or problem started \_\_\_\_\_  
 Pains are  Sharp  Dull  Constant  Intermittent (frequency \_\_\_\_\_)  
 Does the pain radiate?  Yes  No  
 What activities aggravate your condition/pain? \_\_\_\_\_  
 What activities lessen your condition/pain? \_\_\_\_\_  
 Is the condition worse during certain times of the day? \_\_\_\_\_  
 Is this condition interfering with work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Routine? \_\_\_\_\_ Other? \_\_\_\_\_  
 Is the condition getting progressively worse? \_\_\_\_\_  
 Other Doctors seen for this condition \_\_\_\_\_  
 Any home remedies? \_\_\_\_\_  
 Other symptoms:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Tension	<input type="checkbox"/> Irritability	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Stiff Neck	<input type="checkbox"/> Pins & Needles in Legs	<input type="checkbox"/> Pins & Needles in Arms
<input type="checkbox"/> Numbness in Fingers	<input type="checkbox"/> Depression	<input type="checkbox"/> Numbness in Toes	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever	<input type="checkbox"/> Lights Bother Eyes	<input type="checkbox"/> Loss of Memory
<input type="checkbox"/> Ears Ring	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fainting	<input type="checkbox"/> Loss of Smell
<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Stomach Upset	<input type="checkbox"/> Constipation	<input type="checkbox"/> Feet Cold
<input type="checkbox"/> Hands Cold		<input type="checkbox"/> Cold Sweats	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Buzzing in Ears			

Please indicate where your complaint is on the following diagram:



Please rate the pain on the following scale:  
**No Pain** 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 **The Worst Pain Ever**  
 Have you been under drug and medical care? \_\_\_\_\_  
 What medications are you taking? \_\_\_\_\_  
 How Long? \_\_\_\_\_ Have you had surgery? \_\_\_\_\_ What \_\_\_\_\_ When \_\_\_\_\_

