

Personal Health Information

Date:

| | | | | | |
|-------------|----------------------|-------------------------------|-------------------------------|----------------------------------|------|
| Last Name: | | <input type="checkbox"/> Mr. | <input type="checkbox"/> Miss | Marital status (circle one) | |
| First Name: | Middle: | <input type="checkbox"/> Mrs. | <input type="checkbox"/> Ms. | Single / Mar / Div / Sep / Widow | |
| | | <input type="checkbox"/> Dr. | | | |
| Email: | | Birth date: | | Age: | Sex: |
| Address: | | City: | | State: | |
| ZIP Code: | Social Security No.: | Phone #'s: Cell: | | Work: | |
| | | Home: | | | |
| Occupation: | Employer: | | #Hours/week: | | |

Medical Care Information

Do You Have a Family M.D.?: No Yes, Name of M.D.:

Address: City: State: PH#:

Date of last Visit: / / Date of last exam: / /

Have you seen a Chiropractor before?: No Yes, Name of Chiropractor:

Address: City: State: PH#:

Date of last Visit: / / Date of last exam: / /

Have you had surgeries in the last 5 Years: Yes No If yes, Last Surgery Date:

Please list all Surgeries:

Present illness / Conditions:

| | | | | | |
|--|--|---|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Spinal Disc Disease | |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cirrhosis/hepatitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/ARC | <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dislocated joints | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Polio | <input type="checkbox"/> |
| <input type="checkbox"/> Bone fracture | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mental/ Emotional Difficulty | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> STD'S | <input type="checkbox"/> |

Comments/other:

Family History of Illness:

| | | | | | |
|------------------------------------|--|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cancer | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Spinal Disc Disease | <input type="checkbox"/> STD'S | |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bone fracture | <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cirrhosis/hepatitis | <input type="checkbox"/> HIV/ARC | <input type="checkbox"/> Mental/ Emotional Difficulty | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dislocated joints | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diverticulitis |

Other:

If yes to Cancer, What type? Breast Lung Prostate Other:

Social History:

| | | | |
|---|--|---|---|
| Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per week? | Cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes Packs per day? | Caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per day? | Exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes (circle one) Light / Moderate / Strenuous |
|---|--|---|---|

Hobbies:

Personal Health Information

Do you take medications (including OTC)? Yes No If yes, please list for what and how long you've taken.

Do you take vitamin supplements? Yes No If yes, please list with dosage:

Sleep:

Are you able to fall asleep easily? Yes No

Do you wake up at night? Yes No If yes, why? _____ Any specific time of night? _____

Do you feel rested in the morning? Yes No How many hours on average do you sleep? _____

Do you: Have Nightmares Sleep Walk Snore Grind Teeth Have to Nap during the day

Typical Daily Diet:

Approximately how many ounces of Water do you drink per day? _____ Sodas? How much? _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks(and when): _____

Quality of Life:

What is your greatest health concern? _____

How does it limit you the most? _____

How could it affect your relationships? _____

What is your Primary Goal regarding your health?

To Optimize My Health To Maintain my Current Level of Health Pain/Symptom Relief

Other:

Personal Health Information

Stresses of Life:

Research proves that physical, mental/emotional, and/or chemical stress is involved in most health conditions. Please help us to determine the cause of your condition by answering the following questions thoroughly.

What is your most stressful situation currently?

What do you believe caused your current condition?

Regarding Physical Stress to the body, please indicate if you've ever experienced any of the following:

- Car Accidents or "Fender-Benders" Repetitive Work/tasks Poor posture habits (i.e. Slouching)
- Slip and/or Falls Fights/Wrestling Sports Bike Accidents Motorcycle Accidents
- Other: _____

Space Reserved for Office Use:

Signature: _____

Date: _____

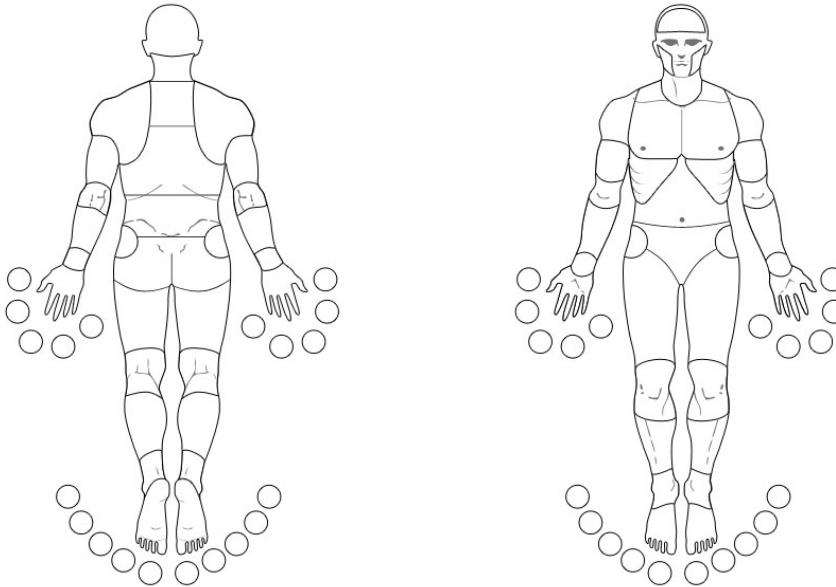
All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Personal Health Information

Name: _____

Date: _____

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow.



| | | |
|---|------------|---|
| Describe Primary Problem: | | |
| Location | | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center |
| Pain Ratings | | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating) |
| Frequency | | <input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75% |
| Pain Type | | <input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Burning |
| Severity | | <input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe |
| What makes it better? | | <input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing |
| What makes it worse? | | <input type="checkbox"/> Movements <input type="checkbox"/> Bending <input type="checkbox"/> Twisting <input type="checkbox"/> Weight Bearing <input type="checkbox"/> Movements <input type="checkbox"/> Neck Flexion <input type="checkbox"/> Sneezing <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Chewing <input type="checkbox"/> Yawning <input type="checkbox"/> Opening mouth <input type="checkbox"/> Closing mouth <input type="checkbox"/> Range of motion <input type="checkbox"/> pushing/pulling <input type="checkbox"/> Lifting <input type="checkbox"/> Watching T.V. <input type="checkbox"/> Reading <input type="checkbox"/> Working <input type="checkbox"/> Driving <input type="checkbox"/> Housework <input type="checkbox"/> Bright lights <input type="checkbox"/> Loud Noises |
| Does the pain radiate to any other locations? | Upper Body | <input type="checkbox"/> Head <input type="checkbox"/> Forehead <input type="checkbox"/> Back of head <input type="checkbox"/> Right side of head <input type="checkbox"/> Left side of head <input type="checkbox"/> Neck <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye <input type="checkbox"/> Face <input type="checkbox"/> Right Jaw <input type="checkbox"/> Left Jaw <input type="checkbox"/> Right Upper back <input type="checkbox"/> Left Upper back <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Chest <input type="checkbox"/> Left Chest <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs |
| | Mid Body | <input type="checkbox"/> Right Mid back <input type="checkbox"/> Left Mid back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Left Lower back <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Buttock <input type="checkbox"/> Left Buttock <input type="checkbox"/> Groin <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right forearm <input type="checkbox"/> Left forearm <input type="checkbox"/> Right hand <input type="checkbox"/> Left hand <input type="checkbox"/> Right fingers <input type="checkbox"/> Left fingers |
| | Lower Body | <input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes |
| Described as | | <input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing |
| At it's worst | | <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate |
| Associated with | | <input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Visual Problems <input type="checkbox"/> Ringing/Buzzing ears <input type="checkbox"/> Bright light <input type="checkbox"/> Sensitivity <input type="checkbox"/> Loss of balance |
| Comments | | |

Personal Health Information

| | | |
|---|------------|--|
| Describe Secondary Problem: | | |
| Location | | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center |
| Pain Ratings | | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating) |
| Frequency | | <input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75% |
| Pain Type | | <input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Burning |
| Severity | | <input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe |
| What makes it better? | | <input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing |
| What makes it worse? | | <input type="checkbox"/> Movements <input type="checkbox"/> Bending <input type="checkbox"/> Twisting <input type="checkbox"/> Weight Bearing <input type="checkbox"/> Movements <input type="checkbox"/> Neck flexion <input type="checkbox"/> Sneezing <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Chewing <input type="checkbox"/> Yawning <input type="checkbox"/> Opening mouth <input type="checkbox"/> Closing mouth <input type="checkbox"/> Range of motion <input type="checkbox"/> pushing/pulling <input type="checkbox"/> Lifting <input type="checkbox"/> Bright lights <input type="checkbox"/> Loud Noises <input type="checkbox"/> Watching T.V. <input type="checkbox"/> Reading <input type="checkbox"/> Working <input type="checkbox"/> Driving <input type="checkbox"/> Housework |
| Does the pain radiate to any other locations? | Upper Body | <input type="checkbox"/> Head <input type="checkbox"/> Forehead <input type="checkbox"/> Back of head <input type="checkbox"/> Right side of head <input type="checkbox"/> Left side of head <input type="checkbox"/> Neck <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye <input type="checkbox"/> Face <input type="checkbox"/> Right Jaw <input type="checkbox"/> Left Jaw <input type="checkbox"/> Right Upper back <input type="checkbox"/> Left Upper back <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Chest <input type="checkbox"/> Left Chest <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs |
| | Mid Body | <input type="checkbox"/> Right Mid back <input type="checkbox"/> Left Mid back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Left Lower back <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Buttock <input type="checkbox"/> Left Buttock <input type="checkbox"/> Groin <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right forearm <input type="checkbox"/> Left forearm <input type="checkbox"/> Right hand <input type="checkbox"/> Left hand <input type="checkbox"/> Right fingers <input type="checkbox"/> Left fingers |
| | Lower Body | <input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes |
| Described as | | <input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing |
| At it's worst | | <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate |
| Associated with | | <input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Visual Problems <input type="checkbox"/> Ringing/Buzzing ears <input type="checkbox"/> Bright light <input type="checkbox"/> Sensitivity <input type="checkbox"/> Loss of balance |
| Comments | | |

| | | |
|---|------------|--|
| Describe Additional Problem: | | |
| Location | | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center |
| Pain Ratings | | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating) |
| Frequency | | <input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75% |
| Pain Type | | <input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Burning |
| Severity | | <input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe |
| What makes it better? | | <input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing |
| What makes it worse? | | <input type="checkbox"/> Movements <input type="checkbox"/> Bending <input type="checkbox"/> Twisting <input type="checkbox"/> Weight Bearing <input type="checkbox"/> Movements <input type="checkbox"/> Neck flexion <input type="checkbox"/> Sneezing <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Chewing <input type="checkbox"/> Yawning <input type="checkbox"/> Opening mouth <input type="checkbox"/> Closing mouth <input type="checkbox"/> Range of motion <input type="checkbox"/> pushing/pulling <input type="checkbox"/> Lifting <input type="checkbox"/> Bright lights <input type="checkbox"/> Loud Noises <input type="checkbox"/> Watching T.V. <input type="checkbox"/> Reading <input type="checkbox"/> Working <input type="checkbox"/> Driving <input type="checkbox"/> Housework |
| Does the pain radiate to any other locations? | Upper Body | <input type="checkbox"/> Head <input type="checkbox"/> Forehead <input type="checkbox"/> Back of head <input type="checkbox"/> Right side of head <input type="checkbox"/> Left side of head <input type="checkbox"/> Neck <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye <input type="checkbox"/> Face <input type="checkbox"/> Right Jaw <input type="checkbox"/> Left Jaw <input type="checkbox"/> Right Upper back <input type="checkbox"/> Left Upper back <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Chest <input type="checkbox"/> Left Chest <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs |
| | Mid Body | <input type="checkbox"/> Right Mid back <input type="checkbox"/> Left Mid back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Left Lower back <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Buttock <input type="checkbox"/> Left Buttock <input type="checkbox"/> Groin <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right forearm <input type="checkbox"/> Left forearm <input type="checkbox"/> Right hand <input type="checkbox"/> Left hand <input type="checkbox"/> Right fingers <input type="checkbox"/> Left fingers |
| | Lower Body | <input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes |
| Described as | | <input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing |
| At it's worst | | <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate |
| Associated with | | <input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Visual Problems <input type="checkbox"/> Ringing/Buzzing ears <input type="checkbox"/> Bright light <input type="checkbox"/> Sensitivity <input type="checkbox"/> Loss of balance |