



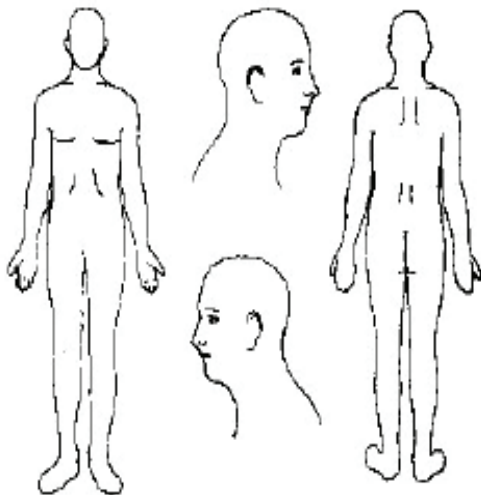
Date of Birth _____ Age: _____ S.S. # _____
 Last Name _____ First Name _____
 Address _____ Apt # _____
 City _____ State _____ Zip Code _____
 Phone (H) _____ (W) _____ (C) _____ E-mail _____
 Contact in case of an emergency _____ Phone # _____ Relationship _____
 Your Occupation _____ Employer _____
 FEMALES: Are you pregnant? ___ No ___ Yes If yes, How many weeks? ___ Date of last menstrual cycle? _____

If patient is a minor (under 18 y/o), please fill out this section. If not, skip this box.
 Parent/Guardian's Name _____ Relationship _____ DOB: _____ Age _____
 Address _____ Apt # _____
 City _____ State _____ Zip Code _____
 Phone (H) _____ (W) _____ (C) _____ E-mail _____
 Occupation _____ Employer _____

WHAT BRINGS YOU TO THIS OFFICE?

FIRST COMPLAINT _____

▶ Date when symptoms first appeared: _____ ▶ Have you had this condition before? Y N
 ▶ Is this condition related to : Work Auto Date of accident: _____ Have you lost days from work? Y N
 ▶ Did it begin Gradual Y N Sudden Y N How many days? _____
 ▶ What makes the symptom increase? _____
 ▶ What relieves the symptoms? _____
 ▶ Type of pain ___ Sharp ___ Dull ___ Aching ___ Burning ___ Throbbing
 ▶ Does the pain radiate into your L R Shoulder-Arm-Hand L R Buttox-Leg-Foot ___ Does not radiate
 ▶ Do you experience numbness and tingling? Y N How often do you get pain? 100% 75% 50% 10%



Place an "X" on the drawing on areas causing you pain and a letter describing it

S = STABBING
N = NUMBNESS
B = BURNING
A = ACHING
P = PINS & NEEDLES

PAIN INTENSITY

Please circle the number that best describes your pain
0 1 2 3 4 5 6 7 8 9 10
NONE LITTLE MEDIUM SEVERE

Patient Signature _____

OTHER COMPLAINT

- ▶ Date when symptoms first appeared: _____ ▶ Have you had this condition before? Y N
- ▶ Did it begin Gradual Y N Sudden Y N How many days? _____
- ▶ What makes the symptom increase? _____
- ▶ What relieves the symptoms? _____
- ▶ Type of pain ___ Sharp ___ Dull ___ Aching ___ Burning ___ Throbbing
- ▶ Does the pain radiate into your L R Shoulder-Arm-Hand L R Buttox-Leg-Foot ___ Does not radiate
- ▶ Do you experience numbness and tingling? Y N How often do you get pain? 100% 75% 50% 10%

PAIN INTENSITY Please describe the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10
 NONE LITTLE MEDIUM SEVERE

If you have additional complaints to address with the doctor, please let the front desk know. They will give you an additional form.

PREVIOUS ACCIDENT HISTORY

Have you ever been involved in another motor vehicle accident?

Yes No Please describe briefly with dates: _____

PRESENT ACCIDENT HISTORY

Date of accident: _____

Street and Address: _____

Were any tickets issued and to whom? _____

Please indicate if you were the/at: Driver

Front seat Back seat L or R Other _____

Did the impact to your vehicle come from the: Front Rear

Right Side Left side Did the air bag deploy? Yes No

Did you hit anything inside the vehicle? No Yes

If yes, describe: _____

Did you experience immediate pain? No Yes

Did the ambulance/paramedics arrive at the scene? Yes No

Were you taken to the hospital? No Yes

Did you drive to the hospital? No Yes

If yes, which hospital? _____

Were x-rays taken? No Yes

Did they prescribe any medication? No Yes

Are you currently taking other medication? No Yes

If yes, please name: _____

Please briefly describe the accident in your own words:

SOCIAL HISTORY

▶ Do you drink alcohol? No Yes

If yes how much? _____

▶ Do you use tobacco (smoke or chew)?

No Yes How much? _____

▶ Do you use any other drugs?

No Yes If yes, how much

and which ones? _____

Please if you have experienced any of the following since this accident

- Nausea Neck Pain
- Vomiting Mid-Back Pain
- Ringing in ears Low-Back Pain
- Headaches Dizziness
- Changes in vision Brain Fog
- Difficulty swallowing Numbness
- Difficulty talking Tingling
- Difficulty with balance Other
- Hand/Arm/Shoulder Pain
- Buttox/Leg/Foot Pain
- Bowel/Bladder difficulty

Doctor's Name: _____

Signature: _____

Date: _____

Please list all previous treatments for this condition:

Name of treating physician _____ Dates of treatment _____
 Type of treatment or drugs prescribed _____

Name of treating physician _____ Dates of treatment _____
 Type of treatment or drugs prescribed _____

Please list all past surgeries:

Type _____	When _____
Type _____	When _____
Type _____	When _____
Type _____	When _____

- | | |
|---|---|
| ▶ Have you ever suffered a stroke? Y N | ▶ Anyone in your family had a stroke? Who/Age _____ |
| ▶ Have you ever had a heart attack? Y N | ▶ Anyone in your family had a heart attack? Who/Age _____ |
| ▶ Do you have vascular disease? Y N | ▶ Anyone in your family have vascular disease Who/Age _____ |
| ▶ Do you have high blood pressure? Y N | ▶ Anyone in your family have high blood pressure? Who/Age _____ |
| ▶ Do you smoke? Y N How much? _____ | ▶ Have you ever smoked in the past? Y N How much? _____ |
| ▶ Do you take birth control pills? Y N | ▶ Have you ever taken birth control pills? Y N |

Barre Leiou + -

George's Test + -

Please list any medications or vitamins you are currently taking:

- | | |
|--|---------------------------------------|
| ▶ When was your last Visit to the chiropractor? _____ | ▶ Were you helped? Y N |
| ▶ What spinal correction program were you given? _____ | |
| ▶ Did you follow it? _____ | ▶ How did the post x-rays look? _____ |

Please mark X for present conditions, O for past conditions

- | | | | |
|------------------------------|--------------------------------|---|----------------------------|
| ____ Fractured bones | ____ Sinus Problems | ____ Fainting | ____ Varicose Veins |
| ____ Auto Accidents | ____ Eating Disorders | ____ Loss of Balance | ____ Liver Trouble |
| ____ 0-1 year ago | ____ Trouble Sleeping | ____ Blurred vision R L | ____ Gall Bladder Trouble |
| ____ 1-5 years ago | ____ Trouble Concentrating | ____ Double Vision R L | ____ Digestive Problems |
| ____ more that 5 years ago | ____ Learning Disability | ____ Upper Back Pain/Stiffness | ____ Heartburn |
| ____ Other accidents/ Falls | ____ Mood changes | ____ Mid back Pain/Stiffness | ____ Ulcers |
| ____ Back curvature | ____ Headache | ____ Low BackPain/Stiffness | ____ Diarrhea/Constipation |
| ____ Arthritis | ____ Pain/Stiff Neck R L | ____ Numbness, Tingling or Pain | ____ Colon Trouble |
| ____ Diabetes | ____ Numbness/Tingling/Pain | ____ In buttocks, thighs, legs, feet, toes. | ____ Hemorrhoids |
| ____ Swollen/Painfull joints | ____ Arms/Hands/Fingers | ____ Pain with cough/sneeze | ____ Prostate Problems |
| ____ Convulsions/Epilepsy | ____ R L | ____ Hip Pain R L | ____ Impotence |
| ____ Skin Problems | ____ Jaw Pain/ TMJ R L | ____ Foot Trouble R L | ____ Kidney Trouble |
| ____ Cancer | ____ Head/Shoulders Feel Tired | ____ Chest Pain | ____ Menstrual Problems |
| ____ Frequent Colds/Flu | ____ Difficulty in Excessive | ____ Asthma | ____ Menopausal Problems |
| ____ Depressed | ____ Standing Lifting | ____ Lung Problems | ____ Pregnant (Now) |
| ____ Irritable | ____ Walking Household duties | ____ Difficulty breathing | ____ Bed Wetting |
| ____ Anemia | ____ Bending Twisting | ____ Heart Problem | ____ Ear Infection |
| ____ Tremors | ____ Riding | ____ Stroke | ____ AIDS/HIV |
| ____ Allergies | ____ Shoulder Pain R L | ____ High/Low Blood Pressure | ____ Last Menstrual Period |

PATIENT'S NAME: _____

DATE: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

GENERAL INFORMATION:	
Any recent weight gain/loss	Y N
Weakness	Y N
Fatigue	Y N
Fever	Y N
Fainting spells	Y N
Nausea	Y N
Vomiting	Y N
Balance problems	Y N
Jaw pain	Y N
Neck Pain	Y N
Neck Stiffness	Y N
Shoulder Pain	Y N
Arm Pain	Y N
Wrist /Hand Pain	Y N
Numbness arms or hand	Y N
Upper back pain	Y N
Lower back pain	Y N
Hip pain	Y N
Leg Pain	Y N
Ankle /Foot Pain	Y N
Numbness Legs or Feet	Y N
Joint swelling	Y N
Tension	Y N
Nervousness	Y N
Anxiety	Y N
Irritability	Y N
Sleeping Problems/Insomnia	Y N
Depression	Y N
Liver problems	Y N
Cancer (if yes indicate what type)	

Metal implants	Y N
If yes indicate where: _____	

HEAD	
Headaches	Y N
Loss of consciousness	Y N
Dizziness	Y N
Memory problems	Y N
Seizures/Convulsions	Y N

EYES	
Wear Glasses/Contact Lenses	Y N
Double vision	Y N
Blurred Vision	Y N
Eyes sensitive to light	Y N

EARS	
Loss of hearing	Y N
Ringing/Buzzing in ears	Y N
Ear infections	Y N
Vertigo (Dizziness)	Y N
Any discharge from ears	Y N

NOSE	
Sinus Problems	Y N
Epitaxis (Nosebleeds)	Y N
Loss of smell	Y N
Any discharge form nose	Y N

MOUTH/THROAT	
Tooth Pain	Y N
Any Lesion/Sores in mouth or lips or gums	Y N
Frequent sore throats	Y N
Difficulty swallowing	Y N
Thyroid problems	Y N

RESPIRATORY (LUNG)	
Difficulty Breathing	Y N
Chronic Cough	Y N
Asthma	Y N
Bronchitis	Y N
Emphysema	Y N
Tuberculosis	Y N
Pneumonia	Y N

Date of last chest x-ray	

CARDIOVASCULAR(HEART)	
Chest Pain	Y N
Difficulty Breathing (Shortness of Breath)	Y N
Palpitations	Y N
Night sweats	Y N
Cold extremities	Y N
High blood Pressure	Y N
Low Blood Pressure	Y N
Heart Murmur	Y N
Ever had an EKG/ECG	Y N

GI (Gastrointestinal)	
Upset stomach	Y N
Loss of appetite	Y N
Indigestion	Y N
Constipation	Y N
Diarrhea	Y N
Blood Stool	Y N
Abdominal Pain	Y N
Excessive Gas	Y N
Loss of bowel control	Y N

ENDOCRINE	
Cold or Heat intolerance	Y N
Excessive sweating	Y N
Excessive thirst or hunger	Y N
Diabetes (If yes indicate if Insulin dependent)	Y N

Thyroid problems	Y N
Kidney Problems	Y N

GU(GENITOURINARY)	
FEMALES	
History of Pelvic Inflammatory Disease	Y N
Urinary Tract Infections	Y N
Breast Cancer &/or Benign Tumors	Y N
Blood in Urine	Y N
Painful urination	Y N
Vaginal discharge	Y N
PMS	Y N
Loss of Bladder Control	Y N
Currently pregnant	Y N
Use Birth Control Pills	Y N
Date of last menstrual period	_____
If indicated age of menopause	_____
Last Pelvic Exam (Date and Results)	_____
Last Pap Smear (Date and Results)	_____
Last Breast Exam (Date and Results)	_____
Any Sexual transmitted disease (STDs)	Y N
MALES	
Prostate Problems	Y N
Hernias	Y N
Penile Discharge	Y N
Blood in urine	Y N
Frequent urination	Y N
Testicular pain	Y N
Loss of bladder control	Y N
Last Prostate Exam (Date and Results)	_____
Last PSA Date and Results	_____
Any Sexual transmitted disease (STDs)	Y N

PATIENT SIGNATURE :
X _____

DATE:
X _____