

WELCOME TO PRIMARY CARE CHIROPRACTIC

LAST NAME	FIRST	MI	AGE	DATE OF BIRTH	SEX	MS	TODAY'S DATE
STREET ADDRESS				TELEPHONE - AT HOME		AT WORK - OTHER	
CITY			STATE	ZIP CODE	SOCIAL SECURITY NO.		
NAME OF NEAREST RELATIVE	NAME OF SPOUSE			YOUR EMPLOYER		OCCUPATION	
WHO REFERRED YOU TO THIS CLINIC?	NAME OF CHILDREN			EMPLOYER ADDRESS			
TO WHICH DOCTOR?				EMPLOYER-CITY, STATE, ZIP			
E-MAIL ADDRESS				WHO IS RESPONSIBLE FOR THIS BILL			

PRESENT COMPLAINT

PLEASE PRINT

Exact description of your major complaint? _____

What do you believe is wrong with you? _____ Don't know

How long have you had this condition? _____

Have you had this or similar conditions in the past? No Yes When? _____

What do think caused your problem? _____

What activities aggravate your condition? _____

What have you done to make it better? _____

Does your pain radiate or extend to other areas? No Yes, into my _____

Is this condition getting progressively worse? Yes Comes & goes Stays same

This condition limits my ability to: Work Sleep Daily routine _____

List other complaints. _____

How long has it been since you really felt good: Days Weeks Months Years

Why do you think your condition has not cleared up? _____

What would you like to be able to do as your condition improves? _____

Please list other doctors you have seen for your present condition. _____ None

Dr. Name _____ Dr. Name _____

Has the treatment helped? Yes No Don't Know

Previous chiropractic care? No Yes: Dr. _____ Address _____

What are your goals for care?

Symptom relief Prevent from recurring Holistic or Wellness care Correct the problem

MEDICAL HISTORY

Please list all doctors you presently see for any reason.

Family/Primary Doctor	Address	Phone
Doctor Name	Address	Phone
Doctor Name	Address	Phone

Date of last physical exam. _____ Don't know Date of last blood tests _____ Don't know

Type of diagnostic tests in the last year: _____

List all surgical operations and which year: **List all accidents that you have been involved.**

SURGERY	YEAR	AUTO ACCIDENT	YEAR	SEEK CARE?
_____ / _____		Driver/ Passenger	_____	Yes / No _____
_____ / _____		Driver / Passenger	_____	Yes / No _____
_____ / _____		WORK INJURIES	_____	Yes / No _____
_____ / _____		SPORTS INJURIES	_____	Yes / No _____

List any **other injuries, broken bones** or **scars** you may have not listed above.

Have or had cancer? No / Yes: Type _____ **Do you smoke? Yes / No**

I learn best by things : I see I hear I feel

HEALTH

Yes / No	I have had a recent illness or injury that needs evaluation and care.
Yes / No	I have problems that continue to persist or return. I want to get relief by stopping symptoms.
Yes / No	I have problems that continue to persist or return. I want to identify and fix the cause of my complaint to allow healing and prevention.
Yes / No	Do you think good posture can be related to good health?
Yes / No	Do you have problems with digestion, bloating, or heartburn?
Yes / No	Do you feel that Chiropractic care can improve your health? <input type="checkbox"/> Don't know
Yes / No	Has any doctor in the past talk to you about life style changes to be healthier?
Yes / No	Are you interested in taking action steps towards health goals?
Yes / No	I want to maintain health, wellness and practice preventive measures to be healthy.

REVIEW OF SYSTEMS

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe you will be helped, we will not accept your case. THANK YOU.

How often do you go to the dentist? _____ How often do you exercise? _____

How do you choose the food you eat?

- Cheapest and most convenient Taste Foods that make me healthy Other _____

How would you rate your overall health?

- Mostly sick, not healthy Sick and healthy about the same Mostly healthy but frequently sick
 I have good overall health I am healthy and in excellent condition

LEAVE BLANK IF NO

- O - OCCASIONAL**
F - FREQUENT
C - CONSTANT
O F C

GENERAL

- Allergy
- Dizziness
- Fainting
- Fatigue
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Frequent Colds
- Sinus Problems
- Ear noises
- Enlarged thyroid

MUSCLE AND JOINT

- Arthritis
- Low back pain
- Neck pain or stiffness
- Pain or numbness in:
- Shoulders & Arms
- Elbows & Hands
- Hips & Legs
- Knees & Feet
- Poor posture
- Sciatica
- Spinal curvature
- Swollen joints

FOR MEN ONLY

- Prostate trouble
- Frequent urination
- Painful urination

O F C

FOR WOMEN ONLY

- Cramps or backache
- Excessive menstrual flow
- Irregular cycle
- Hot flashes
- Frequent urination
- Painful urination
- Menopausal symptoms
- Painful Menstruation
- Yes No Are you pregnant

DIGESTION

- Belching or gas
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Bloating
- Excessive hunger
- Nausea
- Pain over stomach
- Poor appetite

CIRCULATION AND BREATHING

- High blood pressure
- Low blood pressure
- Pain over heart
- Rapid heart beat
- Asthma
- Chest pain
- Chronic cough
- Difficult breathing

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- Anemia
- Cancer
- Cold sores
- Diabetes
- Epilepsy
- Heart disease
- Miscarriage
- Multiple sclerosis
- Stroke
- Tuberculosis

Are you currently on any of the following medications?

- High Blood Pressure
- Cholesterol
- Anti-anxiety
- Thyroid
- Pain pills
- Muscle relaxers
- Birth Control
- Others _____

Please list any vitamins you take on a regular basis:

- Multi-vitamin
- Calcium
- Vitamin E
- Vitamin C
- Other _____

Please list any recent events or situations that have been particularly stressful.

- _____
- _____

Additional Comments: