

Medical History Information

Last Name:		Middle:		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one) Single / Mar / Div / Sep / Widow Spouse:	
First Name:				<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.		
Email:				Birth date:		Age:	Sex:
Address:			City:		State:		
ZIP Code:		Social Security No.:		Home Phone:			
Occupation:		Employer:			Employer phone:		
Medical Care Information				Referred by: _____			
Do You Have a Family Doctor?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor: _____							
Address:			City:		State:	ZIP Code:	
Date of last Visit: / /				Date of last exam: / /			
Do You Have a Family Chiropractor?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Chiropractor: _____							
Address:			City:		State:	ZIP Code:	
Date of last Visit: / /				Date of last exam: / /			
Have you had surgeries in the last 5 Years: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Last Surgery Date: _____							
Reason for Surgery:							
Present illness /Conditions: PREGNANT: YES or NO							
<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"/>	
<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"/>	
<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"/>	
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:							
Type of Cancer: <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> 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	
Misc.:							

Signature: _____

Date: _____

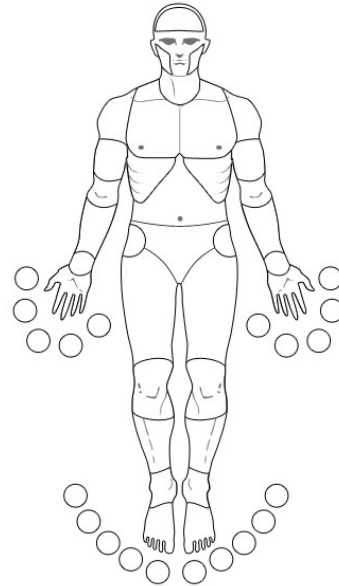
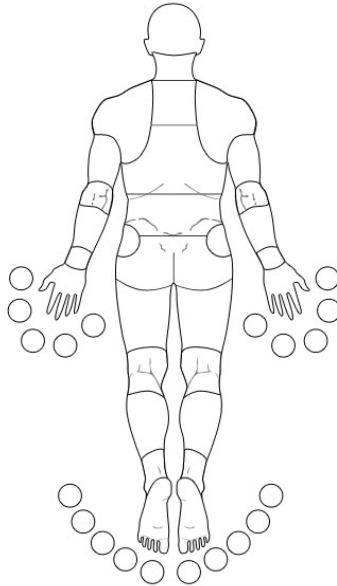
CURRENT COMPLAINTS

Patient's 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.

1. Headaches
2. Neck
3. Upper back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen
25. Pelvis/Groin



***Please SEPARATE for each symptom when filling out Area's of Complaints. Example: If you are experiencing neck AND back pain, fill out Area of Complaint #1 for neck AND Area of Complaint #2 for back. THANK YOU.**

Area of Complaint # 1		Onset date: _____
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		

Area of Complaint # 2		Onset date: _____
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		

Area of Complaint # 3		Onset date: _____
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		

Patient's Signature _____