PATIENT CONDITION

Chief complaint: _____

How long: _____ How often: _____

Severity of pain: **(scale of 1-10)** _____ Quality of pain: **(please circle)** Sharp, Dull, Aching, Burning, Other

What caused this: _____

What treatments have you tried:_____

Does it interfere with your work, sleep, daily routine, or recreation? If so, how:_____

_____

Have you had chiropractic care before? _____ If yes, where/who: _____

Any concerns or fears about chiropractic care? _____ If yes, what: _____

ACCIDENT INFORMATION

Is condition due to an accident? If so, please provide date _____

Type of Accident? **(please circle)** Auto, Work, Home, Other **_____**

Severity of pain: **(scale of 1-10)** _____ Quality of pain: **(please circle)** Sharp, Dull, Aching, Burning, Other

Have you reported this accident? **(please circle)** Yes, No

If yes, to whom? **(please circle)** Auto Insurance, Employer, Work Comp, other _____

Attorney name **(if applicable)** _____

TREATMENT INFORMATION

What treatments have you already received for your condition? **(please circle)**

Medication, Surgery, Physical Therapy, Chiropractic Care, Acupuncture, Massage ,None, Other_____

Name of Practitioner and last date of treatment _____

Last date of Spinal X-ray _____ Physical Exam _____ Blood Test _____MRI _____CT Scan _____

Primary care Physician name and address _____

Are you under the care of any other health care professionals? **(please circle)** Yes, No Who? _____

***Please sign here if you would like a report to be sent to the above named Doctor:**

Patient: _____ Date: _____

PERSONAL INFORMATION

Exercise - **(please circle)** None, Moderate, Daily, Heavy Lifting, Type of exercise _____

Allergies: _____ Caffeine intake: **(how much)** _____

Work Activity- **(please circle)** Sitting, Standing, Light Labor, Heavy Labor, Computer Work

Do you smoke? Yes, No How much? _____

Do you drink alcohol? Yes, No How often? _____

High stress levels? Yes, No Reason: _____