PRECISION CHIROPRACTIC
+ MASSAGE CENTER

Name:_____ Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Birth Date:_____ Age:_____ Sex:_____

Cell Phone:_____ E-mail Address:_____

Employer:_____ Occupation:_____

Referred To This Office By:_____

Name & Number of Emergency Contact:_____ Relationship:_____

Personal Health Insurance (Name):_____ Health Card #:_____

Insured Persons Name:_____ Date of Birth:_____

List Your Major Complaints in Order of Severity

1. _____
2. _____
3. _____
4. _____
5. _____

DO YOU EXPERIENCE ANY OF THE FOLLOWING? IF YES MARK "X"

o Headaches	o Fainting or Seizures	o Diabetes	o Constipation
o Upper Back Pain	o Loss of Balance	o High Blood Pressure	o Neck Pain
o Sinus Trouble	o Ringing of Ears or Ear Aches	o Low Blood Pressure	o Arthritis
o Loss of Smell/Taste	o Hearing Difficulty	o Dizziness / Vertigo	o Tailbone/Sacrum Pain
o Hayfever / Allergies	o Eye / Vision Trouble	o Mid Back or Shoulder	o Painful Joints
o Asthma	o Neck Muscle Spasm	o Acid Reflux or Ulcers	o Swollen Joints
o Cancer	o Fibromyalgia	o Abdominal Pain	o Hip Pain
o Infections	o Tightness in Shoulder Muscles	o Prostate Trouble	o Pins & Needles in Legs
o Thyroid Trouble	o Pain in Shoulders & Arms	o Bladder Problems	o Swollen Ankles
o Sleeping Trouble	o Pins & Needles in Arms & Hands	o Gall Bladder Problems	o Cold Feet
o Facial Pain or Palsy	o Cold Hands	o Kidney Trouble	o Numbness in Legs
o Loss of Memory	o Chest Pains or Rib Pains	o Buttocks Pain	o Knee Pain
o Chronic Fatigue	o Shortness of Breath	o Low Back Pain	o Groin Pain
o Depression / Anxiety	o Carpal Tunnel Syndrome	o Heart Palpitations	o Pain in Legs and Feet

List Any Accidents or Injuries in the Past Year _____

List Any Injuries Between 1-20 Years Ago_____

List Any Injuries Over 20 Years Ago _____

List All Surgeries and When _____

Other Doctors Seen For This Condition_____

Previous Chiropractic Care? _____ When?_____ Where? _____

When did this episode begin? _____ (days, weeks, months, years)

What happened? _____

Has this condition existed in the past?
❑ Yes ❑ No ❑ Yes, but has been dormant
❑ Comes & goes ❑ Symptoms ongoing

How frequent do your symptoms occur? (3,3)
❑ Infrequent ❑ Occasional
❑ Frequent ❑ Constant

How are your daily activities affected? (3,4)
❑ Doesn't affect ❑ Somewhat affects
❑ Seriously affects ❑ Prevents activities

Check the quality of your symptoms
(Check all that apply): (3,2)
❑ dull ❑ sharp ❑ aching
❑ burning ❑ numbing ❑ tingling
❑ spasm ❑ stinging ❑ shooting
❑ stiff ❑ pounding ❑ constricting

Is this condition getting progressively worse?
❑Yes ❑No ❑ Constant ❑ Comes & goes

What relieves your pain? (3,6)
❑ AM ❑ PM ❑ standing ❑ sitting
❑ heat ❑ ice ❑ stretching ❑ exercise
❑ bed rest ❑ nothing ❑ other_____

What aggravates your pain? (3,6)
❑ AM ❑ PM ❑ standing ❑ reaching
❑ sitting ❑ stairs ❑ sneezing ❑ coughing
❑ lifting ❑ bending ❑ neck movement
❑ other_____

Does your pain/symptoms radiate to your: (3,5)
❑ head ❑ face ❑ shoulders ❑ arms
❑ hands ❑ fingers ❑ buttocks ❑ hip
❑ rear thigh ❑ front thigh ❑ calf ❑ shin
❑ ankle ❑ foot ❑ toes

On a scale of 0-10 (10 = the worst) how bad does it get when it's at its worst? _____

Is this condition interfering with your:
❑ work ❑ sleep ❑ daily routine
❑ family life ❑ hobbies ❑ sexual function
❑ social life ❑ other_____

How long has it been since you felt good?
❑ weeks ❑ months ❑ years ❑ other _____

Sleep:
Do you have trouble falling asleep? ❑ Yes ❑ No
Do you awaken in middle of the night? ❑ Yes ❑ No
Do you awaken earlier than normal? ❑ Yes ❑ No
Do not feel well-rested? ❑ Yes ❑ No

Other Health Care Providers you have tried:
❑ Family MD ❑ Neurologist ❑ Physical therapist
❑ Massage ❑ Gynecologist ❑ Orthopedic surgeon
❑ Counselor ❑ Proctologist ❑ Gastroenterologist
❑ Psychiatrist ❑ Psychologist ❑ Ear, nose & throat
❑ Hypnotist ❑ Acupuncturist ❑ Endocrinologist
❑ Allergist ❑ Heart specialist ❑ Pulmonary specialist
❑ Internist ❑ Chiropractor ❑ Rheumatologist
❑ Nutritionist ❑ Kidney specialist ❑ Pain specialist/clinic
❑ Other

Check off any Tests you have received:
❑ X-Rays ❑ MRI ❑ CAT scan
❑ EKG ❑ Allergy test ❑ Nerve conduction test
❑ EMG ❑ Bone scan ❑ Bone density test
❑ Myelogram ❑ Ultrasound ❑ Other _____

Check off any Treatments you have tried:
❑ OTC drugs ❑ Ice ❑ Prescription drugs
❑ Massage ❑ Cortisone shots ❑ Electrical stimulation
❑ Heat ❑ Ultrasound ❑ Physical therapy
❑ Ointments ❑ Surgery ❑ Acupuncture
❑ Traction ❑ Manipulation ❑ Other _____

Work History:
Do your present complaints affect the number of hours you work per day? ❑ Yes ❑ No

Are you working beyond your physical limitations because you ***have*** to work? ❑ Yes ❑ No

Job involves: ❑ Lifting ❑ Bending ❑ Stooping
❑ Twisting ❑ Turning ❑ Carrying ❑ Walking
❑ Sitting ❑ Other _____

Has this caused you to miss work? ❑Yes ❑No
If so, how much? _____ Last day worked? _____

If **RETIRED**, what occupation did you retire from?

_____

If **DISABLED**, What is your disability and how long have you been disabled?

What was your last employed function?

Check any MEDICATIONS you are taking, including Over-The-Counter (OTC) & Prescription (Rx):

(check all that apply)	OTC	Rx
Headaches	❑	❑
Pain	❑	❑
Muscle Relaxants	❑	❑
Arthritis	❑	❑
Steroids	❑	❑
Sinus/Allergy	❑	❑
Asthma/Bronchitis	❑	❑
Sleeping	❑	❑

(check all that apply)	OTC	Rx
Diabetes	❑	❑
Water Pills	❑	❑
Heart/Cardiovascular	❑	❑
Blood Pressure	❑	❑
Cholesterol	❑	❑
Ulcers	❑	❑
Depression/Anxiety	❑	❑
Psychological	❑	❑

(check all that apply)	OTC	Rx
Bowels/Laxative	❑	❑
Hormones	❑	❑
Thyroid	❑	❑
Antibiotics	❑	❑
Birth Control		❑
Heartburn/Stomach	❑	❑
Other	❑	❑
NOT TAKING Medications	❑	❑

(4,1) Do you have difficulties with any of the following ACTIVITIES? (check all that apply)

- ❑ Bathing
- ❑ Showering
- ❑ Washing Hair
- ❑ Standing
- ❑ Sitting
- ❑ Reclining
- ❑ Prolong Standing
- ❑ Carry objects
- ❑ Carry briefcase
- ❑ Bowling
- ❑ Golfing
- ❑ Concentrating
- ❑ Drying Hair
- ❑ Combing Hair
- ❑ Washing Face
- ❑ Walking
- ❑ Stooping
- ❑ Squatting
- ❑ Prolong sitting
- ❑ Lift from floor
- ❑ Lift from table
- ❑ Jogging
- ❑ Dancing
- ❑ Seeing
- ❑ Brushing Teeth
- ❑ Making Bed
- ❑ Putting on shirt
- ❑ Kneeling
- ❑ Reaching
- ❑ Bending forward
- ❑ Prolonged walk
- ❑ Pushing
- ❑ Pulling
- ❑ Swimming
- ❑ Skiing
- ❑ Hearing
- ❑ Put on shoes
- ❑ Tying shoes
- ❑ Put on pants
- ❑ Bending back
- ❑ Bending left
- ❑ Bending right
- ❑ Prolong kneel
- ❑ Exercise upper
- ❑ Exercise lower
- ❑ Ice Skating
- ❑ Roller skating
- ❑ Preparing meals
- ❑ Eating
- ❑ Washing dishes
- ❑ Twisting left
- ❑ Twisting right
- ❑ Leaning forward
- ❑ Climbing inclines
- ❑ Climbing stairs
- ❑ Exercise arms
- ❑ Comp Sports
- ❑ Hobbies
- ❑ Tasting
- ❑ Put Trash out
- ❑ Laundry
- ❑ Going to toilet
- ❑ Leaning left
- ❑ Leaning right
- ❑ Leaning back
- ❑ Driving car
- ❑ Using keyboard
- ❑ Exercise legs
- ❑ Dating
- ❑ Dining out
- ❑ Smelling

REVIEW OF SYSTEMS (check all that apply)

General
- ❑ Chills
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Sweats

Genito-Urinary
- ❑ Blood in urine
- ❑ Lack of bladder control
- ❑ Painful urination

Eyes
- ❑ Crossed eyes
- ❑ Double vision
- ❑ Vision - Flashes
- ❑ Vision - Halos
- ❑ Blurred vision

Ears/Nose/Throat
- ❑ Earache
- ❑ Ear Discharge
- ❑ Loss of hearing
- ❑ Nose bleeds
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Persistent cough

Respiratory
- ❑ Cough
- ❑ Congestion
- ❑ Distress
- ❑ Sputum
- ❑ Shortness of breath

Endocrine
- ❑ Weight gain
- ❑ Weight loss
- ❑ Hoarseness
- ❑ Heat Intolerance
- ❑ Cold Intolerance
- ❑ Breast Changes
- ❑ Hair Changes
- ❑ Extreme Thirst

Gastrointestinal
- ❑ Bloating
- ❑ Bowel changes
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting no blood
- ❑ Vomiting with blood

Cardiovascular
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose vein

Integumentary (skin)
- ❑ Bruise easy
- ❑ Hives
- ❑ Change in moles
- ❑ Sores that won't heal
- ❑ Itching
- ❑ Unusual swelling
- ❑ Sores/ulcers
- ❑ Rash

Women Only
- ❑ Are you pregnant? __
- ❑ Number of children __
- ❑ Other _____

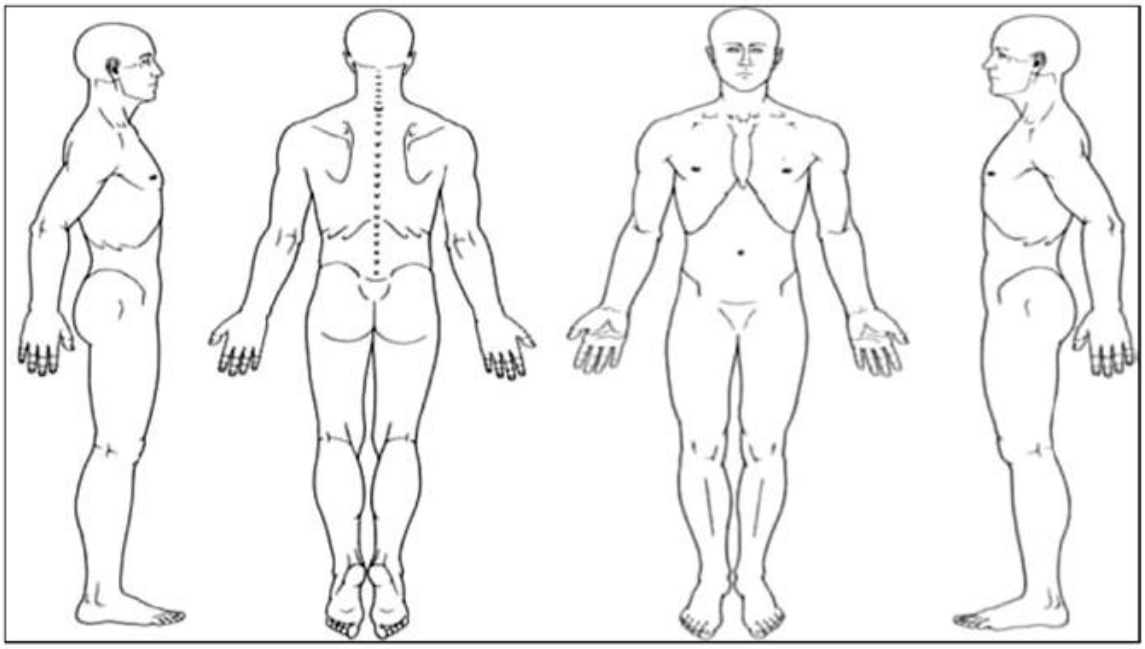
Neurological
- ❑ Seizures
- ❑ Vertigo
- ❑ Dizziness
- ❑ Hand Trembling
- ❑ Loss of Sensations
- ❑ Loss of facial expression
- ❑ Weak Grip
- ❑ Paralysis
- ❑ Difficulty of Speech
- ❑ Numbness
- ❑ Un-coordination

Psychiatric
- ❑ Trouble Sleeping
- ❑ Irritable
- ❑ Hallucinations
- ❑ Loss of Memory
- ❑ Drug Addiction
- ❑ Extreme Worry
- ❑ Suicidal Thoughts

Conditions
- ❑ AIDS
- ❑ Alcoholism
- ❑ Appendicitis
- ❑ Bleeding Disorders
- ❑ Breast Lumps
- ❑ Bronchitis
- ❑ Cancer
- ❑ Cataracts
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Epilepsy

Conditions
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pneumonia
- ❑ Polio
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Fever
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Other _____

Please outline on the diagram any area of discomfort:



Signature:_____ **Date:**_____