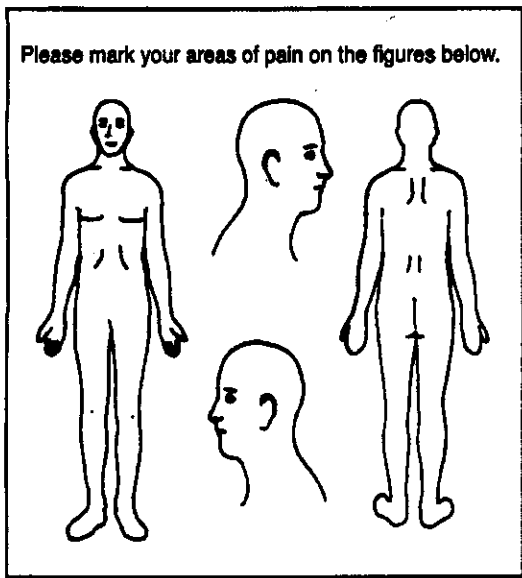


LAST NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 OCCUPATION _____
 EMPLOYER _____
 # OF CHILDREN _____ PHONE _____ CELL _____

FIRST NAME _____ PREFERRED _____
 SS# _____ BIRTHDATE _____ AGE _____
 EMAIL _____
 SPOUSE _____
 SPOUSE'S OCCUPATION _____
 REFERRED BY _____

MY GOAL FOR CONSULTING WITH THE DOCTOR: Temporary Relief Lasting Correction Let Doctor Recommend The Best Type of Care

What is your major complaint? _____
 Timing 0-25% 26-50% 51-75% 76-100% of the time
 What caused it? How did it start? (Gradual/Injury) _____
 Was it related to a work or auto accident? _____
 When was the first time you became aware of this problem? How long have you had it? _____
 Constant Comes and Goes _____ Is it progressively getting worse? Yes No
 Medications you are on now: _____
 What makes it better? _____ Worse? _____
 Describe the problem when it is at its worst? (Check all that apply) Dull Achy Sharp Shooting Refers into my arms
 Refers into my legs Other _____
 What activity would you like to be able to do again that is difficult or that YOU CANNOT DO NOW? _____
 This was a new/old illness. What Treatment have you had? _____



Please mark your areas of pain on the figures below.

Mark any other symptoms you have had in the past 6 months.
 Rate the severity of your problem: 1-10 (1—slight problem, 10—severe problem) pain.
 Leave blank if doesn't apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Shoulder Problems | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Numbness - Arms | <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Exzema |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Low Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Poor Digestion |
| <input type="checkbox"/> Numbness - Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Loss Of Feeling | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Stiff Joints | <input type="checkbox"/> Ear Pain / Noises | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Restricts Daily Activities | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Restricts Regular Exercise | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Elbow | <input type="checkbox"/> High / Low |
| <input type="checkbox"/> Dificulty Speling | <input type="checkbox"/> Headaches | <input type="checkbox"/> Tiredness / Fatigue |
| <input type="checkbox"/> Sore Muscles | | <input type="checkbox"/> Foot Pain |

Surgeries/Hospitalization _____
 Have you had an MRI/CT Scan? _____ Dates _____
 Previous Chiropractic Care _____
 Date of last adjustment _____
 Female: Are you pregnant at this time? Yes No Due Date _____
 Do you have a pacemaker? Yes No
 Primary care physician: _____ Phone number: _____
 Physical/Massage Therapist: _____ Phone number: _____
 Personal Trainer: _____ Phone number: _____

TRAUMA FROM BIRTH TO PRESENT, PLEASE LIST BY DATE/DESCRIBE
 1) Injuries or Falls _____
 2) Broken Bones _____
 3) Car/Bike Accidents _____
 Do you have any metal in your body? Yes No
 If yes, where? _____

Signature: _____ Date: _____

Doctor's Notes:

- | | | |
|---|---|---|
| Shoulder ROM -
Flex - 180
Ext. - 60
Abd - 150
Add - 35
Internal Rotation - 90
External Rotation - 90 | Elbow -
Flex - 160
Ext. - 0
Pronation - 90
Supination - 90 | Wrist -
Flex - 90
Ext. - 70
Ulnar Deviation - 65
Radial Deviation - 20 |
| | Hip -
Flex - 125
Ext. - 15
Add - 45
Abd - 45
External Rotation - 45
Internal Rotation - 45 | Ankle -
Plantar Flexion - 80
Dorsiflexion - 20 |
| | | Knee -
Flexion - 130
Ext. - 0 |

Patient Name _____

Date _____

Condition's Effect On Job Performance: No Effect Mild (painful can do) Mod (painful limited ability)
 Mod/Sev (limited duty) Sev (no limited duty) Sev (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

- Bending: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Care -Infirm Family: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Carrying Groceries: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Change Posn-Sit-Stand: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Climb Stairs: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Driving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Extended Computer Use: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Feeding: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Household Chores: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Kneeling: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Lift Children: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Lifting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Pet Care: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Reading (Concentration): No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care-Bathing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care-Dressing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care-Shaving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Sexual Activities: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Sleep: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static Sitting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static Standing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Walking: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Yard Work: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

- _____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform
- _____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform
- _____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform

Please answer the following questions carefully and answer each one honestly:
check YES or NO

1. Has your doctor ever said that you have a heart conditions and that you should only do physical activity recommended by a doctor?
 YES NO
 2. Do you feel pain in your chest when you were not doing physical activity? YES NO
 3. In the past month, have you had chest pain when you were not doing physical activity?
 YES NO
 4. Do you lose your balance because of dizziness or do you ever lose consciousness?
 YES NO
 5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity? YES NO
 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? YES NO
- Do you know of any other reason why you should not do physical activity? YES NO
