

CONFIDENTIAL HEALTH INFORMATION

All information that you provide us is strictly confidential and will not be transferred without your permission.

Date _____

Name _____

First name _____

Address _____

Date of birth _____

Phone number _____

Email _____

Have you consulted a chiropractor before?

Yes No

Gender

Male female

Marital Status

Single Married
 Divorced Widowed

Which health insurance do you have?

Christian Mut. Liberal Mut.
 Social Mut. Other

Your Occupation

1. The symptom(s) that have prompted me to seek care today include: _____

2. And are the result of

An accident or injury
 Work Car Other _____

A worsening long term problem
 An interest in: Wellness Other _____

3. Onset (When did you first notice your current symptoms?) _____

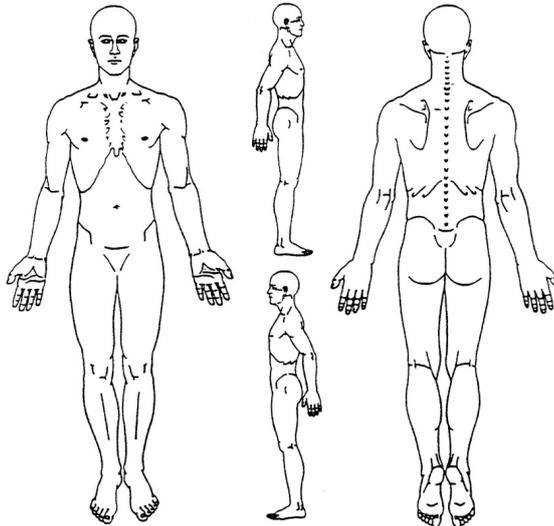
4. Intensity (How extreme are your current symptoms?) 0 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 10

Absent Uncomfortable Agonizing

5. Duration and timing (When did it start and how often do you feel it?)

Constant Comes and goes. How often? _____

6. Location (Where does it hurt?) Circle the area(s) on the illustration.



7. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

8. **Aggravating or relieving factors** (What makes it better or worse, such as time of day, movements, certain activities, etc.)

9. **Prior interventions** (What have you done to relieve the symptoms?)

- | | | |
|--------------------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Prescription medication | <input type="checkbox"/> Surgery | <input type="checkbox"/> Ice |
| <input type="checkbox"/> Over-the-counter drugs | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Homeopathic remedies | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Massage | |

10. Review of Systems

Chiropractic care focusses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have**.

A. Musculoskeletal

- | | | | | | |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| Had Have
<input type="checkbox"/> <input type="checkbox"/> Osteoporosis | Had Have
<input type="checkbox"/> <input type="checkbox"/> Arthritis | Had Have
<input type="checkbox"/> <input type="checkbox"/> Scoliosis | Had Have
<input type="checkbox"/> <input type="checkbox"/> Neck pain | Had Have
<input type="checkbox"/> <input type="checkbox"/> Back problems | Had Have
<input type="checkbox"/> <input type="checkbox"/> Hip disorders |
| <input type="checkbox"/> <input type="checkbox"/> Knee injuries | <input type="checkbox"/> <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> <input type="checkbox"/> Shoulder problems | <input type="checkbox"/> <input type="checkbox"/> Elbow /wrist pain | <input type="checkbox"/> <input type="checkbox"/> TMJ issues | <input type="checkbox"/> <input type="checkbox"/> Poor posture |

B. Neurological

- | | | | | | |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| Had Have
<input type="checkbox"/> <input type="checkbox"/> Anxiety | Had Have
<input type="checkbox"/> <input type="checkbox"/> Depression | Had Have
<input type="checkbox"/> <input type="checkbox"/> Headache | Had Have
<input type="checkbox"/> <input type="checkbox"/> Dizziness | Had Have
<input type="checkbox"/> <input type="checkbox"/> Pins and needles | Had Have
<input type="checkbox"/> <input type="checkbox"/> Numbness |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|

C. Cardiovascular

- | | | | | | |
|------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| Had Have
<input type="checkbox"/> <input type="checkbox"/> High blood pressure | Had Have
<input type="checkbox"/> <input type="checkbox"/> Low blood pressure | Had Have
<input type="checkbox"/> <input type="checkbox"/> High cholesterol | Had Have
<input type="checkbox"/> <input type="checkbox"/> Poor circulation | Had Have
<input type="checkbox"/> <input type="checkbox"/> Angina | Had Have
<input type="checkbox"/> <input type="checkbox"/> Excessive bruising |
|------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|

D. Respiratory

- | | | | | | |
|-----------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| Had Have
<input type="checkbox"/> <input type="checkbox"/> Asthma | Had Have
<input type="checkbox"/> <input type="checkbox"/> Apnea | Had Have
<input type="checkbox"/> <input type="checkbox"/> Emphysema | Had Have
<input type="checkbox"/> <input type="checkbox"/> Hay fever | Had Have
<input type="checkbox"/> <input type="checkbox"/> Shortness of breath | Had Have
<input type="checkbox"/> <input type="checkbox"/> Pneumonia |
|-----------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|

E. Digestive

- | | | | | | |
|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| Had Have
<input type="checkbox"/> <input type="checkbox"/> Anorexia/Bulimia | Had Have
<input type="checkbox"/> <input type="checkbox"/> Ulcer | Had Have
<input type="checkbox"/> <input type="checkbox"/> Food sensitivities | Had Have
<input type="checkbox"/> <input type="checkbox"/> Heartburn | Had Have
<input type="checkbox"/> <input type="checkbox"/> Constipation | Had Have
<input type="checkbox"/> <input type="checkbox"/> Diarrhea |
|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------|

F. Sensory

- | | | | | | |
|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| Had Have
<input type="checkbox"/> <input type="checkbox"/> Blurred vision | Had Have
<input type="checkbox"/> <input type="checkbox"/> Ringing in the ears | Had Have
<input type="checkbox"/> <input type="checkbox"/> Hearing loss | Had Have
<input type="checkbox"/> <input type="checkbox"/> Chronic ear infection | Had Have
<input type="checkbox"/> <input type="checkbox"/> Loss of smell | Had Have
<input type="checkbox"/> <input type="checkbox"/> Loss of taste |
|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|

G. Integumentary

- | | | | | | |
|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| Had Have
<input type="checkbox"/> <input type="checkbox"/> Skin cancer | Had Have
<input type="checkbox"/> <input type="checkbox"/> Psoriasis | Had Have
<input type="checkbox"/> <input type="checkbox"/> Eczema | Had Have
<input type="checkbox"/> <input type="checkbox"/> Acne | Had Have
<input type="checkbox"/> <input type="checkbox"/> Hair loss | Had Have
<input type="checkbox"/> <input type="checkbox"/> Rash |
|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------|

H. Endocrine

- | | | | | | |
|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| Had Have
<input type="checkbox"/> <input type="checkbox"/> Thyroid issues | Had Have
<input type="checkbox"/> <input type="checkbox"/> Immune disorders | Had Have
<input type="checkbox"/> <input type="checkbox"/> Hypoglycemia | Had Have
<input type="checkbox"/> <input type="checkbox"/> frequent infection | Had Have
<input type="checkbox"/> <input type="checkbox"/> Swollen glands | Had Have
<input type="checkbox"/> <input type="checkbox"/> Low energy |
|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|

I. Genitourinary

- | | | | | | |
|------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| Had Have
<input type="checkbox"/> <input type="checkbox"/> Kidney stones | Had Have
<input type="checkbox"/> <input type="checkbox"/> Infertility | Had Have
<input type="checkbox"/> <input type="checkbox"/> Bedwetting | Had Have
<input type="checkbox"/> <input type="checkbox"/> Prostate issues | Had Have
<input type="checkbox"/> <input type="checkbox"/> Erectile dysfunction | Had Have
<input type="checkbox"/> <input type="checkbox"/> PMS symptoms |
|------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|

J. Constitutional

- | | | | | | |
|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| Had Have
<input type="checkbox"/> <input type="checkbox"/> Fainting | Had Have
<input type="checkbox"/> <input type="checkbox"/> Low libido | Had Have
<input type="checkbox"/> <input type="checkbox"/> Poor appetite | Had Have
<input type="checkbox"/> <input type="checkbox"/> Fatigue | Had Have
<input type="checkbox"/> <input type="checkbox"/> Sudden weight gain/loss | Had Have
<input type="checkbox"/> <input type="checkbox"/> Weakness |
|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|

