



Name \_\_\_\_\_ M F Age \_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Marital Status S M D W Name of Spouse/significant other \_\_\_\_\_

Occupation \_\_\_\_\_ Emergency contact \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Date of last Chiropractic Visit \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason \_\_\_\_\_

**For Women: Are you pregnant? Yes No**

**Please list (in order of importance) the 3 main areas in your health that you would like to improve.**

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_

**Please circle the symptoms that you either have now or have had within the past year.**

Back pain	Numbness	Fatigue	Hair loss
Neck pain	Cold hands/feet	Ears ring	Depression
Leg/knee/foot pain	Asthma	Chest pain	Nail fungus
Shoulder pain	Allergies	Food cravings	Catch colds easy
Elbow/wrist pain	Indigestion	Skin problems	Constipation
Headaches	Hot flashes	Earaches	Diarrhea
Dizziness	Hormone problems	Sinus problems	Arthritis
Insomnia	High blood pressure	Feeling old	Fainting
Frequent urination	Anger/Irritability	Palpitations	Increased sweating
Cancer	Thyroid	Neuropathy	Auto-immune

**Any other health condition(s) we should know about Yes No \_\_\_\_\_**

**What Type of Care are You Seeking?**

**Temporary relief only**

**Permanent relief**

**Permanent relief and Prevention**

# Current State of Health

**What is the main reason for your visit to our office today?**

**How long have you had this problem?**

**When is it at its worst; what does it feel like?**

**What do you think caused the problem?**

**What percent of the time do you experience these problems? Please circle.  
Intermittent (0-25%) Occasional (26-50%) Frequently (51-75%) Constantly (75-100%)**

**What makes it better and What makes it worse?**

**How is your current health interfering with your daily life?**

**Does your current health make you feel older than you really are?**

**What one thing would you like to be able to do that your current health is stopping you from doing?**

**Is your current health condition (circle): getting better? getting worse? or staying the same?**

**Do any family members have the same or similar condition(s)?**

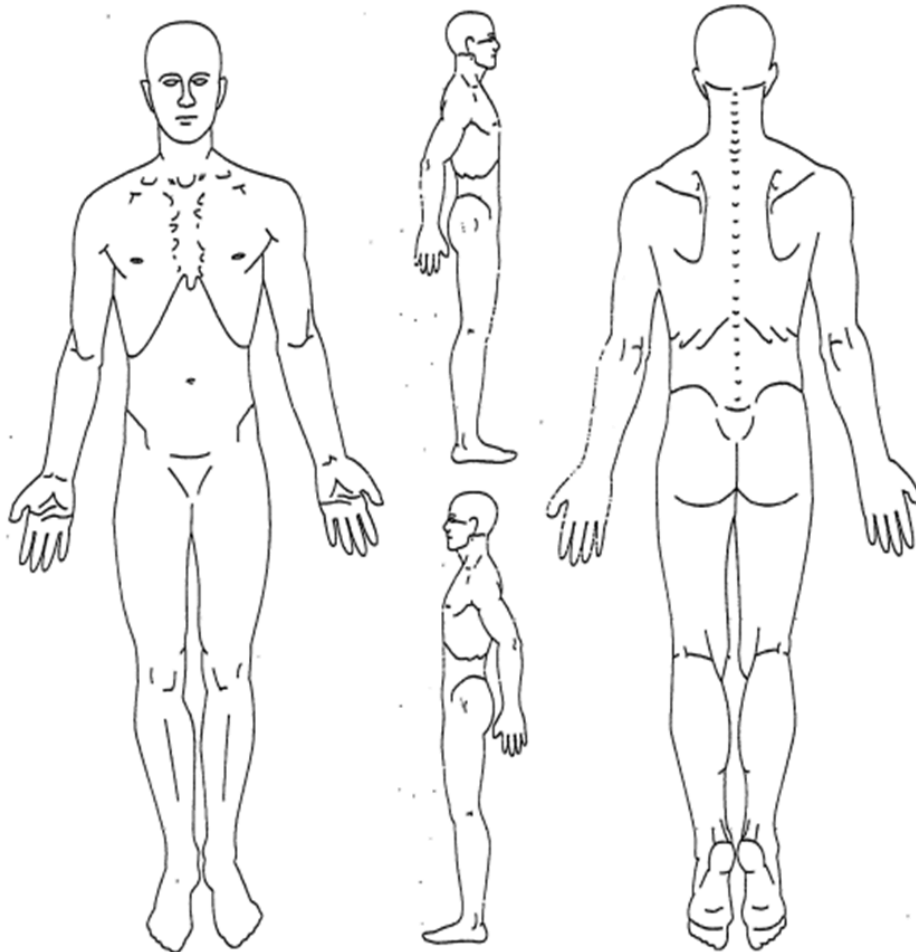
**What have you tried to improve your health in the past? (please circle all that apply)**

Prescription drugs    Over-the-Counter drugs    Heat    Massage    Ice    Supplements  
Acupuncture    Chiropractic    Physical Therapy    Counseling    Rest    Exercise  
Hypnosis    Homeopathy    Meditation    Surgery    Injections    Herbs    Yoga    Special  
Diet  
OTHER:

**Please circle the location of your pain or discomfort on the images below.  
Use the letters shown to represent the type(s) of pain:**

**D** = Dull  
**B** = Burning  
**N** = Numb

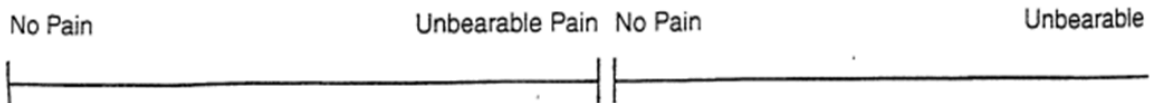
**S** = Stabbing/Cutting  
**T** = Tingling (Pins & Needles)  
**C** = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

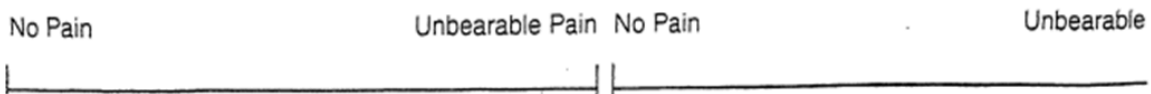
Rate the pain you have right **now**:

Rate your pain at its **best** in the past week:



Rate your **average** pain in the past week:

Rate your **worst** pain in the past week:



# Functional Rating Index

In order to properly assess your condition, we must understand how much it affects your ability to manage everyday activities. For each item, please circle the number which most closely describes your condition right now.

## 1. Pain Intensity

0-----1-----2-----3-----4  
 No Mild Moderate Severe Worst  
 pain pain pain pain possible  
 pain

## 2. Sleeping

0-----1-----2-----3-----4  
 Perfect Mildly Moderately Greatly Totally  
 sleep disturbed disturbed disturbed disturbed  
 sleep sleep sleep sleep sleep

## 3. Personal Care (washing, dressing, etc.)

0-----1-----2-----3-----4  
 No Mild Moderate Moderate Severe  
 pain; pain; pain; need pain; need pain; need  
 no no to go slowly some 100%  
 restrictions restrictions assistance assistance

## 4. Travel (driving, etc.)

0-----1-----2-----3-----4  
 No Mild Moderate Moderate Severe  
 pain on pain on pain on pain on pain on  
 long trips long trips long trips short trips short trips

## 5. Work

0-----1-----2-----3-----4  
 Can do Can do Can do Can do Cannot  
 usual work usual work 50% of 25% of work  
 plus unlimited no extra usual usual  
 extra work work work work

## 6. Recreation

0-----1-----2-----3-----4  
 Can do Can do Can do Can do Cannot  
 all most some a few do any  
 activities activities activities activities activities

## 7. Frequency of pain

0-----1-----2-----3-----4  
 No Occasional Intermittent Frequent Constant  
 pain pain; 25% pain; 50% pain; 75% pain; 100%  
 of the day of the day of the day of the day

## 8. Lifting

0-----1-----2-----3-----4  
 No Increased Increased Increased Increased  
 pain with pain with pain with pain with pain with  
 heavy heavy moderate light any  
 weight weight weight weight weight

## 9. Walking

0-----1-----2-----3-----4  
 No pain; Increased Increased Increased Increased  
 any pain after pain after pain after pain after  
 distance 1 mile ½ mile ¼ mile all walking

## 10. Standing

0-----1-----2-----3-----4  
 No pain Increased Increased Increased Increased  
 after pain pain pain pain  
 several after several after after  
 hours hours 1 hour ½ hour standing

Name: \_\_\_\_\_ (Printed) Signature: \_\_\_\_\_ Date: \_\_\_\_\_ SCORE \_\_\_\_\_

**Is your current health affecting any of the activities below? (Please circle)**

<b>Work:</b>	Yes No	<b>Recreation:</b>	Yes No	<b>Sleep:</b>	Yes No
<b>Social life:</b>	Yes No	<b>Walking:</b>	Yes No	<b>Sitting:</b>	Yes No
<b>Exercise:</b>	Yes No	<b>Eating:</b>	Yes No	<b>Family:</b>	Yes No
<b>School:</b>	Yes No	<b>Marriage:</b>	Yes No	<b>Finances:</b>	Yes No

**PHYSICAL TRAUMA:**

Have you **ever** had accidents related to the following? (Circle all that apply and give dates)

Automobile    Motorcycle    Bicycle    Sports    Other: \_\_\_\_\_

*If yes, please explain:* \_\_\_\_\_

Have you **ever** injured your spine or nerve system? (Head, neck, back, pelvis, hips):    Yes    No

*If yes, please explain:* \_\_\_\_\_

Do you (or anyone else) crack your back or neck?    Yes    No    Who \_\_\_\_\_

Have you **ever** broken any bones or injured any part of your body?    Yes No

*If yes, please explain:* \_\_\_\_\_

Have you **ever** had surgery or been hospitalized?    Yes    No

*If yes, please explain:* \_\_\_\_\_

How many times a week do you exercise? 0 1 2 3 4 5 6 7 (Please Circle)

How many **total** hours a day do you sit (work, TV, driving, school, etc.) \_\_\_\_\_

How many **total** hours a day are you on a cordless phone, cell phone or headset \_\_\_\_\_

Last Medical Doctor Visit \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Reason: \_\_\_\_\_

## LIFESTYLE INFORMATION:

What is your blood type? \_\_\_\_\_ Do you follow a specific diet Yes/No \_\_\_\_\_

**How often do you consume? N =Never/Rarely D =Daily W =Weekly M =Monthly**

Alcohol\_\_ Coffee \_\_ Tobacco\_\_ Diet Soda \_\_ Fast Food \_\_ Candy \_\_ Dairy\_\_ Wheat\_\_ Corn\_\_

Are you sensitive to bright light? Y N How much water do you drink daily? \_\_\_\_\_

How would you rate your memory over the last 5 years? Same Better Worse

Do you get a headache or feel shaky if you skip a meal? Y N

Height \_\_\_\_\_ Weight \_\_\_\_\_

How many hours per night do you sleep? \_\_\_\_\_ Do you dream? Y N

How often \_\_\_\_\_

Do you eat breakfast every day? Y N Do you need coffee to get going in the morning? Y N

Were you breastfed? Y N Food Allergies? \_\_\_\_\_

## DAILY STRESS

On a scale of 0-10, with 0 = No Stress and 10 = Extreme Stress, describe your stress levels:

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**QUALITY OF LIFE (0=worst 10=best)**

- How do you grade your physical health?      0 1 2 3 4 5 6 7 8 9 10
- How do you grade your emotional health?      0 1 2 3 4 5 6 7 8 9 10
- How do you grade your nutritional health?      0 1 2 3 4 5 6 7 8 9 10
- How do you rate your **overall** "quality of life"?      0 1 2 3 4 5 6 7 8 9 10

**Terms of Acceptance**

The Chiropractic Place specializes in the detection, correction, and prevention of the vertebral subluxation complex (stress-related neuro-spinal disorders). We do not treat or diagnose medical conditions nor dispense drugs. Today's visit will evaluate the current health of your spine and nerve system. If we accept your case, you will receive recommendations outlining the steps to improve your health. Our methods include spinal adjustments, nutrition, and natural health care.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Parent (for minor): \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# HEALTH GOALS:

I would like to: (Check all that apply)

- Have more energy
- Sleep better
- Have less aches and pains
- Get less colds and flu
- Not be dependent on medications
- Feel younger
- Think more clearly
- Be less depressed and enjoy life more
- Reduce my risk of degenerative disease
- Improve my overall quality of life
- Maintain a healthier lifestyle
- Not have to worry about my health

## Rx Prescriptions – Vitamins – Over the Counter Medications

	Prescribed by or Self	NOTES