This is a complete medical history questionnaire. It is important that you fill out this form as completely as you possibly can, so we can give you the best possible health care. Should you have any questions feel free to ask. All information is confidential. PLEASE PRINT.

Date: _____ Account #_____

Name: _____ You go by:_____
First Middle Last

Local address:_____
Street address Appt # PO Box City/State /Zip

Telephone (home) _____-_____-_____ (work) ____-____-_____ (message/cell) ____-____-_____

e-mail_____

Are you (circle): Married Single Divorced Widowed Do you have children? Yes No
How many children do you care for?_____
Your Social Security # _____-_____-_____ Your Date of Birth?____-____-_____ Your Age?_____
Work status? Employer:_____ or (circle): unemployed disabled
How did you find out about us? Friend___ Yellow pages___ Doctor___ Other:_____
Please tell us who referred you here: _____

Student? Y/N If yes, guardian/permanent address: Name : _____
Which school? _____ Address: _____
City/State _____
Phone: ( )_____-_____
Work Phone ( )_____-_____

Major CURRENT complaints, symptoms, and location of pain(s): BE SPECIFIC PLEASE.
_____
_____
_____

When did this problem begin? _____ Have you had this before? Yes No
Tell us about past episode(s):_____
_____
Was this problem caused by: Auto accident? Yes No Job injury? Yes No
Home accident? Yes No Other place? Yes No
Please describe: _____

When did it occur? _____

Describe your pain. Mild Moderate Severe Is it steady? Yes No

Describe how the pain varies: _____
What makes it worse?_____
What makes it better?_____

Is your pain getting (circle): better worse same

Important: Have you been to any other doctors for this (if no skip to "medical history")?:

1. Chiropractors? Yes No If yes, who did you see?_____
   When and for how long?_____
   For what complaint(s)?_____
2. Medical doctors? Yes No If yes, who did you see?_____
   When and for how long? _____
   For what complaint (s)?_____
3. If yes to the above, what did they do (list therapies and tests)?_____
   X-rays? Yes No Did you go to the hospital? Yes No
   Where? _____ Were you admitted? Yes No
   How long did you stay? _____
   Have you lost days from work? Yes No When/how long? _____

Medical History:

Have you **ever** been hospitalized for any reason? Yes No When/what?_____
Have you **ever** been operated on for anything? Yes No When/what_____
Have you **ever** had a broken bone anywhere? Yes No When/what_____
Have you **ever** had a fall of any kind? Yes No When/what_____
Have you **ever** had a car accident? Yes No When/what_____
Do you have any physical impairment ? Yes No Describe_____

Who is your family doctor? _____
Name Address City/State
Last seen by him/her? _____ For what reason?_____

Current medication (**list completely**):_____
Past medication (**list completely**):_____
Current vitamin/herbal products (**list completely**):_____

Have you been diagnosed with any type of disease/condition? Yes No
With what? _____ When? _____
By whom? _____

Please describe anything else about you health you have not told us about already:
_____
_____
_____

- Place a CHECKMARK (√) before any condition that bothers you NOW.
- CIRCLE conditions which you have had in the PAST (whether or not they bother you now)
- How long - length of time problem has existed (days, months or years)

Symptoms	How Long
Head	
☐ Headache	_____
☐ entire head	_____
☐ back of head	_____
☐ forehead	_____
☐ temples	_____
☐ migraine with nausea	_____
☐ migraine without nausea	_____
☐ visual "floaters" w/ migraine	_____
☐ light bothers eyes	_____
☐ sound aggravates headache	_____
☐ Light headed, or fainting	_____
☐ Slurred, or difficult speech	_____
☐ Pain in eyes, flashing lights	_____
☐ Head feels heavy	_____
☐ Loss of memory	_____
☐ Loss of taste or smell	_____
☐ Numbness side of face	_____
☐ Loss of balance, or falling to side	_____
☐ Dizziness/vertigo:	_____
☐ Room spins around me	_____
☐ I spin around the room	_____
☐ Loss of hearing	_____
☐ Pain/ringing or buzzing in ears	_____
Neck	
☐ Pain in neck	_____
☐ Neck pain aggravated by movement	_____
☐ Neck feels out of place	_____
☐ Stiff neck or "arthritis"	_____
☐ Popping/grating/grinding sounds	_____
☐ Muscle spasms	_____
☐ Pinched nerve	_____
Shoulder Joints	
☐ Pain in right shoulder joint	_____
☐ Pain in left shoulder joint	_____
☐ Due to pain, can't raise arm:	
☐ above shoulder level	_____
☐ over head	_____
Hip Joints	
☐ Pain in right hip (ball and socket) joint	_____
☐ Pain in left hip (ball and socket) joint	_____
☐ Pain in hip worse when climbing stairs	_____
Abdomen	
☐ Nervous stomach	_____
☐ Nausea, gas or belching	_____
☐ Constipation	_____
☐ Diarrhea	_____

Symptoms	How Long
Neck, Arms & Hands	
☐ Right arm pain from neck stops at:	
☐ elbow	_____
☐ wrist	_____
☐ fingers	_____
☐ Left arm pain from neck stops at:	
☐ elbow	_____
☐ wrist	_____
☐ fingers	_____
☐ Right arm pins/needles stop at:	
☐ elbow	_____
☐ wrist	_____
☐ fingers	_____
☐ Left arm pins/needles stop at:	
☐ elbow	_____
☐ wrist	_____
☐ fingers	_____
☐ Right hand numb/asleep:	
☐ thumb	_____
☐ first finger	_____
☐ long finger	_____
☐ ring finger	_____
☐ short finger	_____
☐ Left hand numb/asleep:	
☐ thumb	_____
☐ first finger	_____
☐ long finger	_____
☐ ring finger	_____
☐ short finger	_____
☐ Hands cold	_____
☐ Hands or fingers swollen	_____
☐ Arthritis hands or fingers	_____
☐ Loss of grip in right hand	_____
☐ Loss of grip in left hand	_____
Mid Back	
☐ Back pain between shoulders	_____
☐ Mid back pain to chest	_____
☐ Stabbing between shoulders	_____
Chest	
☐ Chest pain	_____
☐ Shortness of breath	_____
☐ Pain around ribs	_____
Women Only	
☐ Menstrual pain severe > 1 day	_____
☐ Cramping excessive > 1 day	_____
☐ Irregularity	_____
☐ Menorrhagia	_____

Low Back Pain

- ☐ Low back pain in middle _____
- ☐ Pain radiates across low back _____
- ☐ Low back pain worse with:
  - ☐ working _____
  - ☐ lifting _____
  - ☐ stooping _____
  - ☐ standing _____
  - ☐ sitting _____
  - ☐ bending _____
  - ☐ coughing, straining at stool _____
  - ☐ lying down on back _____
  - ☐ lying down on side _____
- ☐ Arthritis in back _____
- ☐ Morning stiffness _____
- ☐ Muscle spasms _____

Back, Legs and Feet

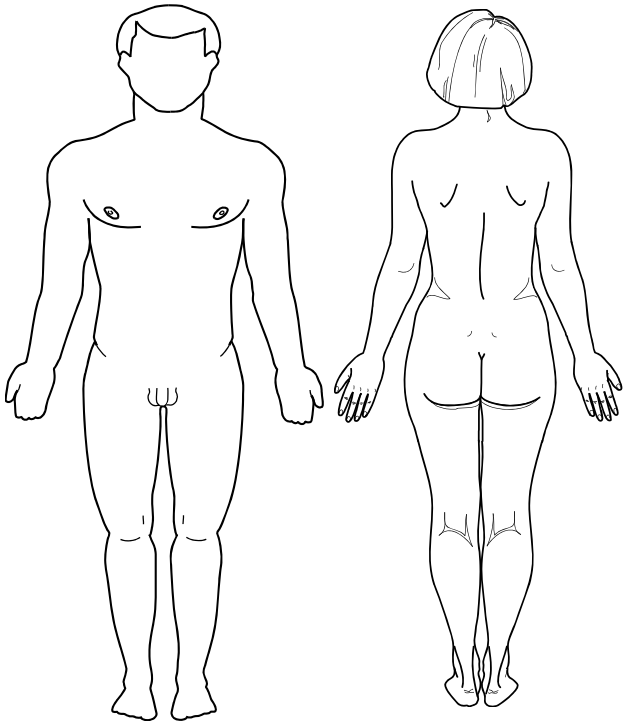
- ☐ Right sided low back pain radiates to:
  - ☐ hip _____
  - ☐ groin/male/female area _____
  - ☐ thigh stops at knee _____
  - ☐ lower leg stops at foot _____
  - ☐ foot _____
- ☐ Left sided low back pain radiates to:
  - ☐ hip _____
  - ☐ groin/male/female area _____
  - ☐ thigh stops at knee _____
  - ☐ lower leg stops at foot _____
  - ☐ foot _____
- ☐ Right sided pins and needles to:
  - ☐ thigh _____
  - ☐ foot on top _____
  - ☐ foot on bottom _____
- ☐ Left sided pins and needles to:
  - ☐ thigh _____
  - ☐ foot on top _____
  - ☐ foot on bottom _____
- ☐ Right foot numb or asleep on:
  - ☐ top _____
  - ☐ big toe _____
  - ☐ bottom _____
- ☐ Left foot numb or asleep on:
  - ☐ top _____
  - ☐ big toe _____
  - ☐ bottom _____
- ☐ Feet cold _____
- ☐ Feet cramp _____
- ☐ Feet/toes swollen _____

Knee Joints

- ☐ Right knee pain _____
- ☐ Left knee pain _____
- ☐ Knees swollen _____

MARK ALL AREAS OF PAIN AND NUMBNESS:

Mark pain with “xxx”
Mark numbness (asleep) with “ooo”:



General

- ☐ Nervousness _____
- ☐ Irritable _____
- ☐ Depressed _____
- ☐ Fatigue all day _____
- ☐ Unrested in AM _____
- ☐ Unexplained weight loss _____
- ☐ Bleeding out any body orifice _____
- ☐ Pain worse at night _____
- ☐ Fever _____