State Street Chiropractic

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Date: ___/___/___

Name: ______________________________ DOB: ___/___/___ Age: ___ Occupation: _______________ SSN: _____-____-_____

Date problem began: ______/______/______ Please describe your problem and how it began: ____

____

How bad is your pain? (Circle a number)	0	1	2	3	4	5	6	7	8	9	10
	No Pain										Unbearable Pain

Do you have any numbness, tingling or pain in: ☐ Left arm ☐ Right arm ☐ Left leg ☐ Right leg

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Occasionally # days per week__

Since it began, is your problem: ☐ Improving ☐ Getting worse ☐ No change

What makes the problem better? ☐ Nothing ☐ Lying down ☐ Walking/Movement ☐ Sitting ☐ Other _______________

What makes the problem worse? ☐ Nothing ☐ Lying down ☐ Walking/Movement ☐ Sitting ☐ Other _______________

Are you able to sleep well at night? ☐ Yes ☐ No

If no, do you have difficulty in: ☐ Falling asleep ☐ Staying asleep

Can you perform your daily home activities? ☐ Yes ☐ Yes, only with help ☐ Not at all

Do you exercise? ☐ Yes. If yes, how many days per week? ____ Type: _________ ☐ Not at all

Describe your job requirements: ☐ Mainly sitting ☐ Light labor ☐ Heavy labor

Can you perform your daily work activities? ☐ Yes, all activities ☐ Only some ☐ Not at all

Describe your stress level: ☐ None to mild ☐ Slight ☐ Moderate ☐ High

What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic) ______________________________

____

It what time frame do you expect your condition to be resolved? ____

Have you had X-rays, MRI or other tests for this condition? YES NO What tests and when? ______________________________

Have you recently suffered from any of the following:

☐ Headaches	☐ Neck Pain	☐ Back Ache	☐ Leg Pain	☐ Numbness
☐ Dizziness	☐ Heart Trouble	☐ Asthma	☐ Tuberculosis	☐ Cancer
☐ Digestive Pains	☐ Anxiety/Depression	☐ Sinus Trouble	☐ Anemia	☐ Epilepsy
☐ Diabetes	☐ Kidney/Bladder Trouble	☐ Ulcers	☐ High Blood Pressure	☐ AIDS
☐ Sleeping Problems	☐ Constipation	☐ Diarrhea	☐ Arthritis	☐ Menstruation Pain/Irregularity
☐ Ringing in the ears	☐ TMJ Pain	☐ Hand/Wrist Pain	☐ Hypoglycemia	☐ Neuritis

Please list any past surgeries, making sure to include dates: ____

____

Please list any medications you are currently taking: ____

Please list any conditions for which you are currently being treated: ____

Please turn page over

Have you ever had any episodes of loss of consciousness? YES NO If yes, what year: ______________________

Have you had any prior significant auto, sport, or spinal injuries? YES NO If yes, please describe: ______________________

____

Did you have any significant birth trauma? YES NO If yes, please describe: ______________________

____

FEMALES ONLY: Are you pregnant? YES NO MAYBE Date of LMP: ______/______/______

Do you now take vitamins or minerals? YES NO If yes, what kind? ______________________

Do you think you may need vitamins or minerals? YES NO If yes, describe briefly? ______________________

Do you have an allergy to any drug? YES NO If yes, what kind? ______________________

On a scale of 1 to 10, 1 being minimum and 10 being maximum, what is your general energy level? 1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10, where would you like your energy to be? 1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10, 10 being excellent and 1 being terrible, rate your diet: 1 2 3 4 5 6 7 8 9 10

Excluding tea, coffee, fruit juices and alcohol beverages, how much pure water do you drink daily? ______ glasses per day.

How many cups of coffee to you drink daily? _______ cups per day.

Do you wear orthotic appliances in your shoes? YES NO If yes, what kind? ______________________

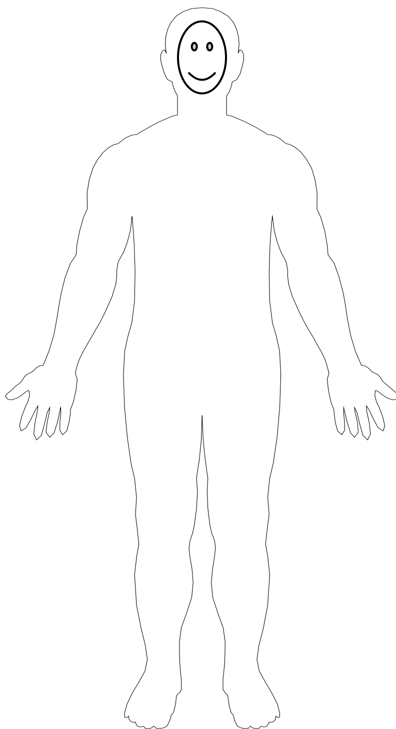
Do you have daily bowel movements? YES NO

TELL US WHERE YOU HURT: Mark the areas on you body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Mark the body in all affected areas with appropriate symbol:

Numbness	+++	Dull/Achy	***	Burning	XXX	Weak	###
Pins & Needles	OOO	Shooting	→→→	Sharp	///		

FRONT



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