

NAME _____

DATE _____

Current Health Conditions or Complaints:

Please put a check mark next to each condition that applies to you.
Please circle L for left, and R for right when necessary.

Head:

Headache: Front _____ Side: L/R _____ Back: _____ Sinus: _____ Migraine: _____ Tension: _____
Dizziness _____ Lightheaded _____ Ringing in Ears _____ Blurry/Double Vision _____
Loss of Balance _____ Loss of Consciousness _____ Fainting _____ Loss of Taste _____ Loss of Smell _____
Other: _____

Neck:

Pain? _____ Stiffness? _____ Burning? _____ Right? _____ Left? _____
Pain with bending neck: forward: _____ to the side: L/R _____ back _____ turning: L/R _____
Pinched Nerve?: L/R _____ Muscle Spasms?: L/R _____ Grinding Sounds? _____ Arthritis? _____
Any history of: Stroke _____ High Cholesterol _____ High Blood Pressure _____ Heart Disease _____
Epilepsy? _____ Other: _____

Shoulders, Arms, Wrists, Hands :

Pain in shoulder joint? L/R _____ Across shoulders? _____ Down one shoulder?: L/R _____
Pain in upper arm? L/R _____ Elbow? L/R _____ ? L/R _____ Wrist ?L/R _____ Hand? L/R _____
Numbness/Tingling in upper arm? L/R _____ Elbow ?L/R _____ Forearm? L/R _____ Wrist? L/R _____
Hand? L/R _____
Loss of Grip Strength? L/R _____ Carpal Tunnel ?L/R _____ Hands get cold?L/R _____
Unable to raise arm? L/R _____ Weakness in arm/hand? L/R _____ Other: _____

Mid-back:

Mid back pain? _____ Stiffness? _____ Muscle Spasms? _____ Rib Pain? _____ Chest Pain? _____
Numbness or tingling? L/R _____ Kidney problems? _____ Difficulty Breathing? _____
Heart conditions (list)? _____ Indigestion? _____ Other: _____

Low Back, Hip, Leg, Ankle, Foot Pain:

Low Back Pain above waistline? _____ Below waistline? _____ Center? _____ Right? _____ Left? _____
Stiffness? L/R _____ Muscle Spasms?L/R _____
Hip Pain L/R _____ Leg Pain L/R _____ Knee Pain L/R _____ Ankle Pain L/R _____ Foot Pain L/R _____
Numbness/Tingling-where? _____
Weakness L/R _____ Urinary difficulties _____ Swollen legs/ankles/feet _____ Prostate problems _____
Menstrual/Reproductive problems? _____ Other: _____

General Information:

Do you have increased stress? _____ anxiety? _____ irritability? _____ fatigue? _____
Do you have trouble lifting? _____ Bending? _____ Twisting? _____ Sitting? _____ Standing? _____ Driving? _____
Working? _____ Doing household chores? _____ walking? _____ exercising? _____ Sleeping? _____
Do you have a history of Cancer? (type) _____ Diabetes? _____ Depression? _____
Fibromyalgia? _____ Chronic Fatigue Syndrome? _____ Other: _____
Have you Gained weight? _____ How much? _____ Lost weight? _____ How much? _____
Do you have any other health history that you think the Doctor should know about at this time? _____

Since these complaints started, what have you tried that did not work? _____

Health begins from within-the better we take care of ourselves the better we will feel from day to day.
Chiropractically, we look to the spine and nervous system to help your body function to its optimum potential each and every day. Since we look to the whole person, we may recommend other alternative treatments (massage, exercises, acupuncture, etc), medical referrals, nutritional advice, or exercise therapies.
Let's begin.....