Patient's Name: ______________________ **Date:** __________

1.) Please choose the location(s) of your problem(s):

	Headaches		Shoulder		Hand		Legs
	Jaw		Arm		Mid Back		Knee
	Neck		Elbow		Low Back		Ankle
	Upper Back		Wrist		Hip		Foot

Other: ______________________

2,) What is your height: __________ Ft. __________ In.

3,) How much do you weigh?: __________ Lbs.

4,) Date of birth: __________

5.) Occupation: ______________________

	Trader		Professional/Executive		White Collar		Trades person		Retired
	Laborer		Homemaker		Truck driver		Student		Unemployed

Other: ______________________

6.) In general, how do you rate your overall health? ______________________

	Excellent		Very good		Good		Fair		Poor

7) What kind of exercise do you perform?

	Strenuous		Moderate		Light		None

8) Do you have an immediate family member with any of the following?

	Rheumatoid arthritis		Hearth problems		Diabetes
	Cancer		Lupus		ALS

Other: ______________________

9) Please check all that apply to you in the appropriate column:

Past	Present		Past	Present		Past	Present		Past	Present	
		Headaches			Joint Pain/Stiffness			Kidney Disorders			Muscular Incoordination
		Neck Pain			Arthritis			Bladder Infection			Visual Disturbances
		Upper Back Pain			Rheumatoid Arthritis			Painful Urination			Dizziness
		Mid Back Pain			Cancer			Loss of Bladder Control			Diabetes
		Low Back Pain			Tumor			Prostate Problems			Excessive Thirst
		Shoulder Pain			Asthma			Abnormal Weight Gain/loss			Smoking Tobacco Use
		Elbow/Upper Arm Pain			Chronic Sinusitis			Loss of Appetite			Drug/Alcohol Dependence
		Wrist Pain			High Blood Pressure			Abnormal Pain			Allergies
		Hand Pain			Heart Attack			Ulcer			Depression
		Hip Pain			Chest Pains			Hepatitis			Epilepsy
		Upper Leg Pain			Stroke			Liver/Gall Bladder Disorder			Dermatitis/Eczema/Rash
		Knee Pain			Angina			General Fatigue			HIV/AIDS
		Ankle/Foot Pain			Kidney Stones	Females Only					Birth Control Pills
		Jaw Pain						Hormonal Replacement			Pregnancy

Other: ______________________

10) Please list all prescription medications you are currently taking:

11) Please list all supplements you are currently taking:

12) Please list all surgical procedures you have had:

113) What do you do at work?

	Sits most of the day		Sits about half the day		Sits a little of the day
	Stands most of the day		Stands about half the day		Stands a little of the day
	Computer most of the day		Computer about half the day		Computer a little of the day
	On the phone most of the day		On the phone about half the day		On the phone a little of the day
	Drives most of the day		Drives about half the day		Drives a little of the day
	Performs manual labor most of the day		Reads a lot about half the day		Travels frequently a little of the day
	None				

14) What do you do outside of work?

	Aerobics		Skiing		Basketball		Soccer		Baseball		Softball
	Bicycling		Swimming		Football		Tennis		Golf		Triathlons
	Hiking		Volleyball		Ice hockey		Walking		Inline skating		Weight lifting
	Jogging		Working out		Martial arts		Yoga		Rock climbing		Other

115) Have you had any hospitalizations?

	Yes		No		Previously mentioned

16) Have you seen a chiropractor before?

	Yes		No

17) Have you had any significant past trauma?

	Yes		No

18) Is there anything else you think I should know?

	Yes		No

120) What did the patient score on the revised neck oswestry index?

21) What did the patient score on the revised lower back oswestry index?

SUBMIT FORM

CLEAR FORM >