

Doctor: _____ Patient number: _____
 Name _____ Spouse _____
 Address _____ SS# _____ D.O.B. _____ Age _____
 City _____ State _____ Zip _____ Home# _____ Work# _____ cell# _____
 Occupation _____ e-mail _____ height _____ ft _____ in weight _____ lbs

What is your major complaint? _____ How long? _____

- | | |
|--|---|
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Shoulder Problems | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Ear Pain |
| <input type="checkbox"/> Numbness-Arm | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Problems between Shoulders | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Low Back Problems | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Numbness-Legs | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Loss of Feeling | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Stiff Joints | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Restricted Daily Activity | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Restricted Regular Exercise | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Sore Muscle | <input type="checkbox"/> Poor Digestion |
| <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Weak muscles | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Pressure |

How did complaint originate? _____
 Is complaint getting worse? Yes ___ No ___
 Type of discomfort (circle one) sharp, dull, aching, numbness/tingling, burning, shooting, stiffness, cramps, swelling, other: _____

How often do you experience the discomfort? (check one)
 ___ constantly ___ frequently ___ occasionally ___ intermittently ___ rarely
 Have you had this condition in the past? ___ yes ___ no if yes, explain: _____

Have you ever seen a chiropractor before? ___ Yes ___ no if yes, explain: _____

Medications: _____

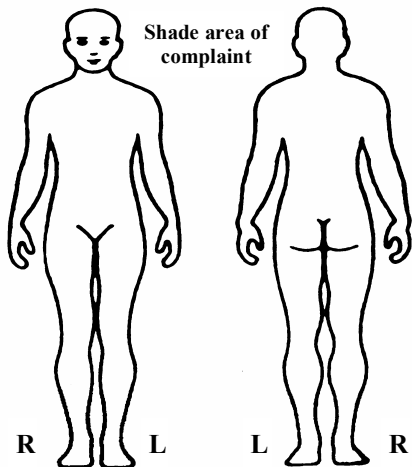
Please list and describe: _____

Car accidents: _____

Falls/injuries and other: _____

Indicate if an immediate family member has had any of the following:

___ Rheumatoid arthritis ___ Heart problems ___ Diabetes ___ Cancer ___ Lupus other _____



	1) X-Ray Date _____ C-Curve _____ C-stress _____ L-Curve _____ L-Stress _____	(Office Use Only) FREQUENCY: C=Constant I=Intermittent O=Occasional IF=Infrequent D=Daily W=Weekly MUSCLES: S.O.=suboccipital TP=Trapezius LS=Levator Scapula RH=Rhomboid SCM=Strenoclast. MS=Muscle Spasm SH=Shoulder CP=Cer Paraspinals TP=Thor Paraspinals LP=Lum Paraspinals
	2) X-Ray Date _____ C-Curve _____ C-stress _____ L-Curve _____ L-Stress _____	
	X-Ray Impression: _____ _____ _____ _____ _____ _____	PAIN: 1=Mild 2=Moderate 3=Severe 4=Very Severe P=Pain S=Same ~=Improve W=Worse ST=Stable EX=Exercise TX=Treatment BGT=Body good
	Other findings: _____ _____ _____ _____	OTHER: PT=Patient HA=Headache TPT=Trigger point BL=Bilateral RT=Right LT=Left N=Neck UB=Upper Back MB=Midback LB=Low Back C=Cervical T=Thoracic

Date of Accident _____ Hour _____ AM _____ PM _____ Location _____

How Did Accident Occur? ___ Auto ___ On the Job Injury ___ Other _____

- Which car were you in? Striking Vehicle _____ Struck Vehicle _____ 2. Seatbelts used ___ Yes ___ No
- Size of striking vehicle- Make _____ Year _____ Weight _____ Speed _____
- Size of struck vehicle- Make _____ Year _____ Weight _____ Speed _____
- Headrest Position ___ Up ___ Down ___ Other _____ 6. Seatback stiffness- Firm _____ Soft _____
- Road Conditions _____
- Direction of Impact _____
- Were you aware of approaching collision? ___ Yes ___ No Did you brace? ___ Yes ___ No
- Did you Brake? ___ Yes ___ No 11. Position of head and torso at impact _____
- Were you unconscious? ___ Yes ___ No Other _____
- Police report filed? ___ Yes ___ No
- List the extent of the injuries as you know them _____

_____ Show Accident

I hereby attest that the above information and health history I have provided is complete and accurate, and that the doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor medical diagnoses.

Patient's/Gaurdian's Signature _____ Date _____