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UPDATE

NAME _____ DATE _____
AGE _____ MARITAL STATUS: M S D W # OF CHILDREN _____
OCCUPATION _____

PHYSICAL ACTIVITIES/HOBBIES _____
TOBACCO USE (PACKS/DAY) _____ CAFFEINE USE (CUPS/DAY) _____
ALCOHOL USE (DRINKS/WEEK) _____ OTHER TOXIN EXPOSURE _____

PRIMARY CARE PRACTITIONER _____
LAST PHYSICAL EXAM _____ LAST BLOOD WORK _____
LAST EYE EXAM _____ LAST DENTAL EXAM _____
HEIGHT _____ WEIGHT _____ R / L HANDED _____
HAS WEIGHT CHANGED IN THE PAST (3) MONTHS? HOW MUCH? _____

LAST MENSTRUAL PERIOD _____ ANY CHANGES W/ CYCLE? _____
LAST GYN EXAM _____ LAST PAP SMEAR _____
LAST MAMMOGRAM _____ LAST BONE DENSITY_____
OF PREGNANCIES _____ TYPE(S) OF DELIVERY _____
IS THERE ANY CHANCE OF PREGNANCY AT THIS TIME? _____

SINCE YOUR LAST ADJUSTMENT AT THIS OFFICE HAVE YOU BEEN INVOLVED IN A MOTOR VEHICLE ACCIDENT?(DATE & INJURIES): _____
_____

HAVE YOU EXPERIENCED ANY PHYSICAL TRAUMA? (SPORTS, SLIP/FALL…)
_____
_____

HAVE YOU HAD ANY SURGERY/MEDICAL PROCEDURES PERFORMED?: _____
_____

HAVE YOU HAD ANY CHANGES IN YOUR OVERALL HEALTH?: _____
_____

PLEASE PROVIDE ANY CHANGES TO YOUR MEDICATIONS (OVER THE COUNTER AND PRESCRIPTIONS): _____
_____

PLEASE PROVIDE ANY CHANGE TO YOUR SUPPLEMENTS/DIETS:
_____

ADDITIONAL COMMENTS: _____
_____

CURRENT HISTORY

WHAT ARE YOUR PRESENT SYMPTOMS/PURPOSE OF THIS CONSULTATION? _____
_____
_____
WHEN DID YOUR SYMPTOM(S) START?: _____
HOW DID YOUR INJURY OCCUR? _____
_____

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOM(S)?:
- A. CONSTANTLY (76-100% OF THE DAY)
- B. FREQUENTLY (51-75% OF THE DAY)
- C. OCCASIONALLY (26-50% OF THE DAY)
- D. INTERMITTENLY (0-25% OF THE DAY)

DESCRIBE THE NATURE OF YOUR SYMPTOMS:

A. SHARP B. DULL ACHE C. NUMB
D. SHOOTING E. BURNING F. TINGLING

WHAT TREATMENT HAVE YOU RECEIVED (INCLUDING HOME CARE)? _____
_____
HAS YOUR PAIN INCREASED, DECREASED OR STAYED THE SAME? _____
HOW HAS YOUR SLEEP QUALITY BEEN AFFECTED BY YOUR SYMPTOM(S)? _____
_____
DOES YOUR PAIN INCREASE WITH COUGHING, SNEEZING, BOWEL MOVEMENT? _____
HOW DOES STANDING, SITTING, OR LYING AFFECT YOUR PAIN? _____
HOW DOES TIME OF DAY AFFECT YOUR SYMPTOM(S)? (AM VS. PM) _____
_____
HOW HAVE YOUR DAILY ACTIVITIES CHANGED? _____
_____
HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? Y / N

IF SO, WITH WHOM DID YOU TREAT?:

A. ANOTHER CHIROPRACTOR B. MEDICAL PRACTITIONER

C. PHYSICAL THERAPIST D. OTHER _____

WHAT DO YOU THINK IS CAUSING YOUR CONDITION? WHAT ARE YOUR CONCERNS?

_____

_____

WHAT ARE YOUR EXPECTATIONS/GOALS OF TREATMENT:(SHORT & LONG TERM)?

_____

_____

PATIENT'S SIGNATURE: _____ DATE: _____

DOCTOR'S SIGNATURE: _____ DATE: _____