Please check all that apply to your current complaint(s) and circle the most severe. Thank you.

☐ Headaches	☐ Neck Stiff	☐ Loss of Memory
☐ Neck Pain	☐ Back Stiff	☐ Ringing in the Ears
☐ Mid Back Pain	☐ Convulsions	☐ Fainting
☐ Low Back Pain	☐ Nervousness	☐ Loss of Smell
☐ Pins + Needles in Arms	☐ Tension	☐ Loss of Taste
☐ Pins + Needles in Legs	☐ Irritability	☐ Diarrhea
☐ Numbness in Fingers	☐ Chest Pain	☐ Constipation
☐ Numbness in Toes	☐ Dizziness	☐ Stomach Upset
☐ Pain in the Arms	☐ Face Flushed	☐ Poor Digestion
☐ Pain in the Legs	☐ Shortness of Breath	☐ Cold Sweats
☐ Pain between Shoulders	☐ Fatigue	☐ Loss of Balance
☐ Hands Cold	☐ Depression	☐ Shortness of Breath
☐ Feet Cold	☐ Eyes Sensitive to Light	☐ Chronic Cough

Have you ever?

Yes	No	
☐	☐	Been Knocked Unconscious?
☐	☐	Used Crutches or other Support?
☐	☐	Been Treated for Spine Problems?
☐	☐	Been Treated for any Nerve Disorder?
☐	☐	Had a Fractured/Broken Bone?
☐	☐	Had Surgery?
☐	☐	Been Hospitalized for Other than Surgery?

Date of Last : (approximate)

_________ Physical Examination
_________ Blood Test
_________ Urine Test
_________ Chest X-ray
_________ Spine X-ray
_________ Dental X-ray
_________ Other

Habits:

Have you in the past or do you currently use:

☐ Alcohol If yes how often? _____________
☐ Coffee How many cups per day?________
☐ Tobacco How many pack per day? ______

Is there a Family History of?

☐ Heart Disease ☐ Arthritis
☐ Cancer ☐ Diabetes
☐ Stroke ☐ ______________

Your Current Problem

What are you current symptoms? ____

What level of intensity would you rate your pain? (10=severe) *1 2 3 4 5 6 7 8 9 10*

What is the frequency of your symptoms? *Occasional / Episodic / Intermittent / Frequent / Constant*

Do your symptoms affect your personal life? (hobbies, sports, etc) ___________________________________

____

Do your symptoms affect your job / occupation?(missed days, inability to stand, sit, lift, drive) ___________

____

How long have you suffered from these symptoms? ____

Have you suffered from these symptoms before? ☐ Yes ☐ No

What makes your symptoms worse? ____

What makes your symptoms better? ____

What home remedies have you tried? ____

Have you been to any other type of doctor for this problem? ______________________________________

Have you been to a Chiropractor before? ☐ Yes ☐ No If Yes, Who?____________________________________

After completing this questionnaire your signature will verify that all information you have given is to accurate to the best of your knowledge.

Signed: ____ **Date:** ___________________

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