SUMNER CHIROPRACTIC CLINIC PC

NAME: DATE OF BIRTH:

List any **Allergies**:

□ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs□ Latex □ Molds □ Penicillin □ Ragweed/Pollen

□ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye □ Other:

List any **Surgeries**:

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist □ Other:

List **ALL Past Medical History** conditions:

□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain □ Depression

□ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain

□ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems □ Hepatitis □ High Blood Pressure

□ Hip Pain □ HIV □ Jaw Pain □ Joint Stiffness □ Knee Pain □ Leg Pain □ Menstrual Problems □ Mid-Back Pain

□ Minor Heart Problem □ Multiple Sclerosis □ Neck Pain □ Neurological Problems □ Pacemaker □ Parkinson's

□ Polio □ Prostate Problems □ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain

□ Stroke/Heart Attack □ Other:

List Type of **Medications** you are taking:

□ Anxiety □ Muscle Relaxers □ Pain Killers □ Insulin □ Birth control □ Cardio-vascular □ Allergy □ Seizure

□ Other:

List your **Immediate Family History**:

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy □ Genetic Spinal Condition

□ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Parkinson's □ Polio

□ Prostate Problems □ Stroke/Heart Attack

Please list all family members who had/has any of the problems above:

Have you been to a chiropractor before? □ No □Yes

Have you had treatment outside of this office for your condition? □ No □Yes If yes, where:

Have you had any auto or other accidents? □ No □Yes Describe:

Date of last physical exam: **Doctor's name:**

Women Only:

Are you pregnant? □ No □Yes If pregnant in the past, were your pregnancies normal? □ No □Yes # of births**?**

OB/GYN Physician's Name: **Date of last exam:**

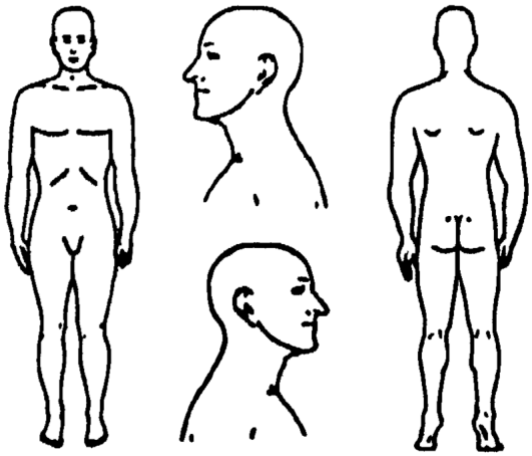
Do you smoke? □ No □Yes

Do you drink alcohol? □ No □Yes - how many per day?

Do you drink caffeine? □ No □Yes - how many per day?

Do you exercise? □ No □Yes (what forms and how often):

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- □ Become pain free
- □ Explanation of my condition
- □ Learn how to care for my condition
- □ Reduce symptoms
- □ Resume normal activity level

What is your major complaint? Date problem began?

How did this problem begin?

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? □ No □Yes

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Tightness

□ Stabbing □ Throbbing □ Other:

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What time of day are you symptoms worse?

How do your symptoms affect your ability to perform daily activities? (0= no effect and 10= no possible activities)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition?

Describe your job activities? Hours worked per week?

Right or Left Handed? □ Right □Left

What makes your pain better?

Signature &Date: