e-mail: _____

INITIAL HEALTH STATUS (Chiropractic)

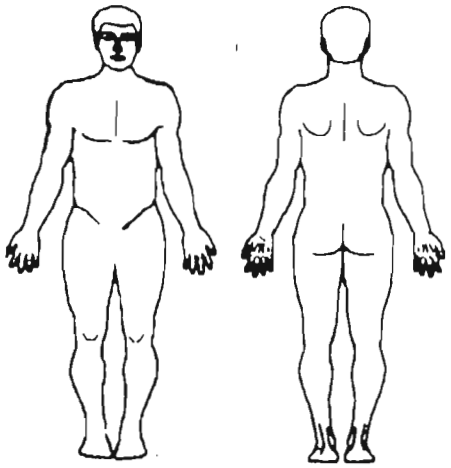
Patient: _____ Birthdate: _____ Sex: M / F

Address: _____ City, State, Zip: _____

Phone: ( ) _____ - _____

PCP: _____ PCP Phone: ( ) _____ - _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain

☐ Other: _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: _____

How Problem Began: _____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How ofter are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Can you perform your daily activities? ☐ Yes ☐ No (Describe current activity limitations) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes Date(s) taken: _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition
☐	☐	History of Recent Infection
☐	☐	Recent Fever
☐	☐	HIV/AIDS
☐	☐	Diabetes
☐	☐	Corticosteroid Use
☐	☐	Birth Control Pills
☐	☐	High Blood Pressure
☐	☐	Stroke (date)_____
☐	☐	Dizziness/Fainting
☐	☐	Numbness in Groin/Buttocks
☐	☐	Urinary Retention
☐	☐	Aortic Aneurysm
☐	☐	Cancer/Tumor
☐	☐	Osteoporosis
☐	☐	Recent Trauma

No	Yes	Condition
☐	☐	Prostate Problems
☐	☐	Frequent Urination
☐	☐	Pregnant, # of weeks _____
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Epilepsy/Seizures
☐	☐	Visual Disturbances
☐	☐	Low/Mid Back Pain
☐	☐	Neck Pain
☐	☐	Arthritis
☐	☐	History of Alcohol Use
☐	☐	History of Tobacco Use
☐	☐	Nocturnal Pain (pain at night)
☐	☐	Surgeries _____
☐	☐	Medications _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be comanaged. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature: _____ Date: _____