FALL RIVER CHIROPRACTIC

Date: _____

Name: _____
Last name First Name Middle initial

DOB: _____
Year Month Day Height Weight

Address: _____
Street City Postal Code

Phone Number: _____
Home Cell Work

Occupation: _____ Employer: _____

Medical Doctor: _____ Health Card Number: _____

Emergency contact: _____ Phone number: _____

Email Address: _____ How did you hear about our office? _____

What is your major complaint today? _____

How long have you had this condition? _____

Describe the onset of this condition: _____

Is the condition getting: (circle) Worse Same Better Consistent Recurring

How would you describe the pain? Aching Throbbing Tingling Numbness
Shooting Constant Intermittent Burning

Do you experience and Numbness or tingling to the arms of legs? Y / N

Is there a particular time of day when your complaint is worse?

Morning Afternoon Evening Night After activities

What activities are you unable to perform due to the pain or functional impairment?

Have you had this condition before? Y / N Were X-rays or other imagining performed? Y / N

What aggravates your condition? _____

What relieves your condition? _____

What types of treatment have you had for this condition? _____

Have you had previous chiropractic care? Y / N

If yes how long has it been since you were last treated? _____

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DO YOU SUFFER – AT PRESENT – FROM ANY OF THE FOLLOWING

( )Fainting/Spells/ Dizziness ( )Fever ( )Chills ( )Difficulty Sleeping
( )Pain the awakens you at night ( )Night sweats ( )General tiredness/ Fatigue
( )Unexplained/Unintentional weight loss

Current Medications (including birth control)

_____
_____
_____

Supplements: _____
_____

List any surgeries/ hospitalizations you've had

_____
_____
_____

Have you suffered and fractures/ dislocations

_____

Health Habits

Smoking: Y / N if yes how many years? _____ packs/day: _____
Exercise: Y / N Drinking alcohol: Y / N Caffeine: Y / N

Please check if you have had any of the following:

Neuromusculoskeletal
( )Convulsions
( )Headaches
( )Backache
( )Stiff neck
( )Pain Between shoulders
( )Spinal Curvature
( )Swollen joints
( )Weakness
( )Twitching
( )Numbness
( )Tremors

Skin or Allergies
( )Allergy
( )Bruise Easily
( )Dryness
( )Eczema
( )Sensitive Skin
( )Shingles

Cardiovascular
( )Heart Disease
( )High blood pressure
( )Low blood pressure
( )Stroke
( )Varicose veins
( )Irregular heartbeat

Gastrointestinal
( )Poor digestion
( )Nausea/ Vomiting
( )Belching/Bloating/Gas
( )Irritable bowel
( )Hemorrhoids

Other
( )Diabetes
( )Cancer
( )Depression/Anxiety
( )Alcoholism
( )HIV positive
( )Thyroid trouble

Respiratory
( )Chest Pain
( )Chronic cough
( )Difficulty breathing
( )Wheezing

Genitourinary
( )Bed wetting
( )Frequent urination
( )Prostate trouble
( )Inability to control urine

Women Only
( )Pregnant
( )Cramping/Backache
( )Miscarriage
( )Irregular Cycle
( )Hot Flashes/ menopausal

Ear/Nose/Throat
( )Earaches
( )Frequent colds/
( )Sinusitis
( )Hayfever

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Mark the areas of your body where you feel the following sensations:

Ache	**Numbness**	**Pins & Needles**	**Burning**	**Stabbing**
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