Name:_____Date_____

What activities make your symptoms worse: _____

What activities make your symptoms better? _____

Who have you seen for your symptoms:_____
(1) No one____(2) Other Chiropractor____(3)Medical Doctor____(4) Physical Therapist____(5) Other___
When and what treatment?_____

What tests have you had for your symptoms? (1) X-Rays/date:_____(3) CT Scan/date:_____
Where?_____(2) MRI/date:_____(4) Other/date:_____

Have you had similar symptoms in the past? Yes No

If you have received treatment in the past for the same or similar symptoms, who did you see? _____
_____(1) This office_____(3) Medical Doctor_____(5) Other_____
_____(2) Other Chiropractor_____(4) Physical Therapist_____

What is your occupation? _____

General Questions:
Headaches: Y N Right side? Left side? Where?_____
Neck pain? Y N With back pains? Y N
Stomach pain? Y N _____
Arm pain? Y N Left? Right? _____
Leg Pain? Y N Left? Right? _____
Do you sleep on your: side?_____stomach?_____back?_____
Do you use pillow(s)? Y N How many?_____ What type?_____

Prior History:

Please list any and all fractures, giving date, how the fractures occurred and if it was casted:_____
_____
_____
Any and all surgeries giving date and reason:_____
_____
_____
Any auto accidents and/or bad falls?_____
_____
_____
Systemic illness such as Diabetes, heart Attack, High Blood Pressure_____
_____
_____
What do you hope to get from your visit/treatment (select all that apply):
(1) reduced symptoms (2) explaination of condition/treatment
(3) resume/increase activity (4) learn how to take care of this on my own
(5) how to prevent this from occuring again (6)_____

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