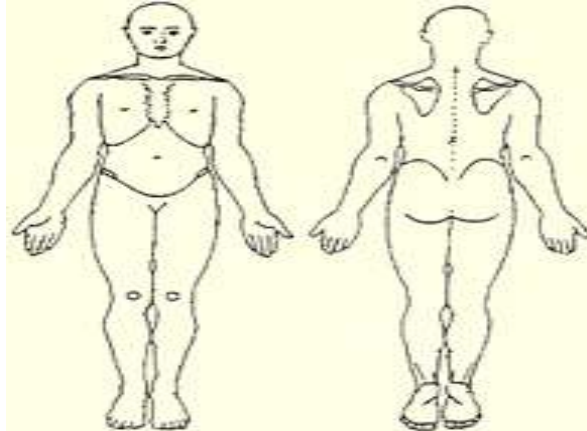


Weum Chiropractic Clinic

Date _____ First Name _____ Middle Initial _____ Last Name _____
Address _____ City/State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer _____ Occupation _____ City/State _____
Email Address _____ Can We send you monthly health tips/info? ____Y ____N
Date of Birth _____ Social Security # _____ Spouse name _____
Children (name/age) _____
How did you hear about our office? _____

1. Is today's problem caused by: Auto Accident Workman's Compensation Other
2. Indicate on the drawings where you have pain/symptoms:



3. How often do you experience your symptoms?
 Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)
4. How would you describe the type of pain?
 Sharp Burning Tingly Electric like w/motion
 Dull Shooting Sharp w/ motion Other: _____
 Diffuse Stiff Shooting w/ motion
 Achy Numb Stabbing w/ motion
5. How are your symptoms changing with time?
 Getting worse Staying the same Getting better
6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10
7. How much has the problem interfered with your work and/or social activities?
 Not at all A little bit Moderately Quite a bit Extremely
8. Who else have you seen for this problem? _____
9. How long have you had this problem? _____
10. How do you think this problem began? _____
11. Do you consider this problem to be severe? Yes Yes, at times No
12. What makes the problem worse? _____
13. What makes the problem better? _____
14. What concerns you the most about this problem; What does it prevent you from doing?

15. How would you rate your overall health?
 Excellent Very Good Good Fair Poor
16. What type of exercise do you do?
 Strenuous Moderate Light None
17. Indicate if you have any immediate family members with any of the following:
 Arthritis Diabetes
 Heart Problems Cancer

18. For each of the conditions listed below, place a check in the "past" column if you've had the condition in the past. If you presently have a condition listed below, check the "present" column.

Past Present	Past Present	Past	Present
<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> Neck Pain	<input type="checkbox"/> <input type="checkbox"/> Heart Condition	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> <input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Frequent Urination
<input type="checkbox"/> <input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> <input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/> <input type="checkbox"/> Low Back Pain	<input type="checkbox"/> <input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/> <input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> <input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Allergies
<input type="checkbox"/> <input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/> <input type="checkbox"/> Bladder Conditions	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Depression
<input type="checkbox"/> <input type="checkbox"/> Wrist/Hand Pain	<input type="checkbox"/> <input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> <input type="checkbox"/> Hip Pain	<input type="checkbox"/> <input type="checkbox"/> Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Epilepsy
<input type="checkbox"/> <input type="checkbox"/> Upper Leg/Knee Pain	<input type="checkbox"/> <input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/> <input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/> <input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> HIV/Aids
<input type="checkbox"/> <input type="checkbox"/> Jaw Pain	<input type="checkbox"/> <input type="checkbox"/> Ulcer		
<input type="checkbox"/> <input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/> <input type="checkbox"/> Liver/Gall Bladder Disorder		For Females Only
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Birth Control Pills
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/> <input type="checkbox"/> Tumor	<input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Pregnancy
<input type="checkbox"/> <input type="checkbox"/> Asthma			
<input type="checkbox"/> <input type="checkbox"/> Chronic Sinusitis			

19. List all prescription medications/over-the-counter medications you are currently taking:

20. What activities do you do at work?

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A Little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A Little of the day
<input type="checkbox"/> Computer Work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A Little of the day
<input type="checkbox"/> On the Phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A Little of the day

21. What activities do you do outside of work?

22. Have you ever been hospitalized? No Yes; Why? _____

23. Have you had significant past trauma? No Yes

24. Have you seen a chiropractor before? No Yes If Yes, when & where? _____

25. Anything else pertinent to your visit today? _____

Patient Signature _____ Date: _____