WEUM CHIROPRACTIC CLINIC

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The Doctor of the future will give no medicine, but will interest his patients in the care of the human frame, in diet, and in the cause and prevention of disease. Thomas A. Edison

NAME____ DATE______________

ADDRESS______________________CITY/STATE_______________ZIP_______

HOME PHONE____________ CELL PHONE____________WORK PHONE____________

EMPLOYER__________________ ADDRESS______________________________

SOCIAL SECURITY #____________________ DATE OF BIRTH________________

SPOUSE NAME___________CHILDREN (NAME/AGE)_______________________

EMAIL ADDRESS__________________CAN WE SEND YOU HEALTH TIPS/INFO ☐ YES ☐ NO

HOW DID YOU HEAR ABOUT OUR OFFICE?_______________________________

PLEASE CHECK THE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH / WELLBEING.

☐ **I am only concerned about relief of a particular symptom.**

☐ **I am only concerned about relief of a particular symptom, and preventing its return.**

☐ **I want optimum health & wellbeing.**
(May include one or more of the following: nutrition/vitamins, exercise/stretches, improvement of daily activities.)

THE HUMAN BODY IS DESIGNED TO EXPRESS HEALTH AND FUNCTION. HOWEVER, EVENTS MAY OCCUR IN LIFE, WHICH CAN INTERFERE WITH THIS NATURAL ABILITY. THIS INTERFERENCE MOST COMMONLY RESULTS FROM VERTEBRAL SUBLUXATION. PHYSICAL, CHEMICAL OR EMOTIONAL STRESS MAY CAUSE THESE SUBLUXATIONS. THE PRACTICE OF CHIROPRACTIC IS BASED ON THE LOCATION AND REDUCTION OF NERVE SYSTEM INTERFERENCE CAUSED BY THE VERTEBRAL SUBLUXATION.

REASON FOR CONSULTING THIS OFFICE

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Mark your area of discomfort on the diagram below.

~Please indicate type of pain felt (Ex. Burning, aching, pins & needles, sharp etc.)________________________

____

~Please rate the pain on a scale of 0 – 10, with 0 being no pain and 10 being intolerable pain.__________

____

Symptoms developed from: Auto accident Work related injury other

When did your symptoms begin?________________ How did it occur?________________

____

What makes your condition better?_________________________________

What makes your condition worse?_________________________________

Does the pain get worse at night, or interfere with your sleep? Y N

Does ice or heat help? Y N

How does the pain interfere with work or living habits?______________________

____

Are you currently suffering from any condition other than that listed above? Y N If yes, what?__________

____

PAST MEDICAL HISTORY

Have you ever seen a chiropractor before? Y N For what condition?________________________________

Dr.'s Name / Location____Last visit?______________

Have you had this condition in the past? Y N If yes, when?________________________________

Have you previously seen a doctor for the condition you are consulting us? Y N

If yes, when?_____________ Where?_______________________ By Whom?___________________________

Diagnosis given?___________________________________ Results?___________________________________

Have you ever been in an automobile accident? Y N ______________________________________

Have you ever had any major illnesses, injuries or falls? Y N ________________________________

Have you ever had any surgeries? Y N ____

Are you currently or have you been taking any over the counter medication/vitamins/ or prescription drugs on a regular basis? Y N ____

____

SOCIAL HEALTH HISTORY

Do you smoke? Y N

Do you exercise? Y N Type of exercise?_____________________________How often?______________

SYSTEMS REVIEW

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD IN THE **PAST 6 MONTHS.**

Musculoskeletal
- Low back pain
- Neck pain
- Pain between shoulders
- Arm pain
- Joint pain/Stiffness
- Walking problems
- Jaw problems

C –V- R
- Chest pain
- Shortness of breath
- Blood pressure problems
- Irregular heartbeat
- Congestion
- Varicose veins
- Ankle swelling
- Stroke

Nervous System
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling limbs
- Stress
- Numbness

EENT
- Vision problems
- Dental problems
- Sore throat
- Ear aches
- Hearing difficulty
- Stuffed nose
- Allergies

Gastrointestinal
- Poor/Excessive appetite
- Excessive thirst
- Frequent Nausea
- Vomiting
- Diarrhea / Constipation
- Gall bladder/Kidney problems
- Liver problems
- Weight trouble
- Abdominal cramps
- Gas / bloating after meals
- Heartburn

Males Only
- Prostate problems
- Sexual dysfunction

Females Only
- Menstrual irregularity
- Menstrual cramps
- Vaginal pain/ infection
- Breast pain / Lumps
- Sexual dysfunction
- When was your last period?____________
- Are you pregnant? Y N Not sure

- **WE ACCEPT PAYMENT BY CASH, CHECK AND CREDIT CARD**
- I understand that all services are to be paid in full at the time of service, unless other arrangements have been made prior and agreed upon in writing.

PATIENT SIGNATURE____ **DATE**________________