State Street Chiropractic
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Date: __/__/__
Name:_____ DOB: __/__/__ Age: __ Occupation: _____ SSN: ___-__-___
Date problem began: ___/___/___ Describe problem and how it began_____
_____

How bad is your pain? (circle a number) **0 1 2 3 4 5 6 7 8 9 10**
No Pain Unbearable Pain

Do you have any numbness, tingling or pain in: ☐ Left arm ☐ Right arm ☐ Left leg ☐ Right leg
How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Occasionally # days per week___
Since it began, if your problem: ☐ Improving ☐ Getting worse ☐ No change
What makes the problem better? ☐ Nothing ☐ Lying down ☐ Walking/Movement ☐ Sitting
☐ Other_____
What makes the problem worse? ☐ Nothing ☐ Lying down ☐ Walking/Movement ☐ Sitting
☐ Other_____
Are you able to sleep well at night? ☐ Yes ☐ No
if no, do you have difficulty in: ☐ Falling asleep ☐ Staying asleep
Can you perform your daily home activities? ☐ Yes ☐ Yes, only with help ☐ Not at all
Do you exercise? ☐ Yes If yes, how many days per week? ___ Type:_____ ☐ Not at all
Describe your job requirements: ☐ Mainly sitting ☐ Light labor ☐ Heavy labor
Can you perform your daily work activities? ☐ Yes, all activities ☐ Only some ☐ Not at all
Describe your stress level: ☐ None to mild ☐ Slight ☐ Moderate ☐ High

What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic) _____
_____
What time frame do you expect your condition to be resolved?_____
Have you had X-rays, MRI or other test for this condition? YES NO What test and when? _____
_____

Have you recently suffered from any of the following:

☐ Headaches	☐ Neck pain	☐ Back ache	☐ Leg pain	☐ Numbness
☐ Dizziness	☐ Heart trouble	☐ Asthma	☐ Tuberculosis	☐ Cancer
☐ Digestive pains	☐ Anxiety/Depression	☐ Sinus trouble	☐ Anemia	☐ Epilepsy
☐ Diabetes	☐ Kidney/Bladder trouble	☐ Ulcers	☐ High Blood Pressure	☐ AIDS
☐ Sleeping problems	☐ Constipation	☐ Diarreah	☐ Arthritis	☐ Mentrual pain/irregularity
☐ Ringing in the ears	☐ TMJ Pain	☐ Hand/Wrist pain	☐ Hypoglycemia	☐ Neuritis

Please list any past surgeries, making sure to include dates: _____
_____
Please list any medications you are currently taking: _____
Please list any conditions for which you are currently being treated: _____

Please turn page over

Have you ever had any episodes of loss consciousness? YES NO If yes, what year: _____

Have you had any prior significant auto, sport or spinal injuries? YES NO If yes, please decribe: _____

_____

Did you have any significant birth trauma? YES NO If yes, please describe: _____

_____

Do you now take vitamins or minerals? YES NO If yes, what kind? _____

Do you think you may need vitamins or minerals? YES NO If yes, describe briefly: _____

Do you have an allergy to any drug? YES NO If yes, what kind? _____

On a Scale of 1 to 10, 1 being minimum and 10 maximum, what is your energy level? **1 2 3 4 5 6 7 8 9 10**

On a Scale of 1 to 10, where would you like your energy to be? **1 2 3 4 5 6 7 8 9 10**

On a Sacle of 1 to 10, 10 being excellent and 1 terrible, rate your diet: **1 2 3 4 5 6 7 8 9 10**

Excluding tea, coffee, fruit juices and alcohol beverages, how much pure water to you drink daily? _____ glasses per day.

How many cups of coffee you drink daily? _____ cups per day.

Do you wear orthotic appliances in your shoes? YES NO If yes, what kind? _____

Do you have daily bowel movements? YES NO

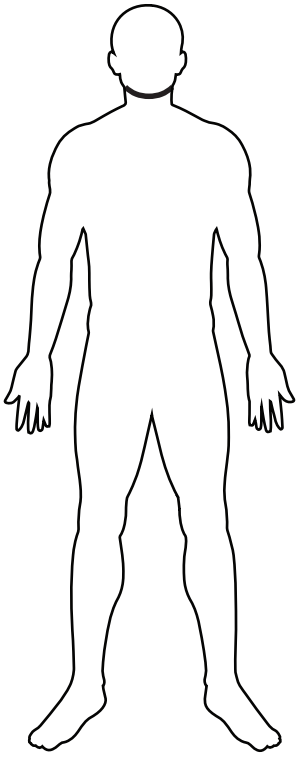
Females Only: Are you Pregnant? YES NO MAYBE Date of LMP: ___/___/___

TELL US WHERE YOU HURT: On the diagram below, mark the areas of the body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below

Mark the body in all affected areas with the appropriate symbol:

Numbness	+++	Dull/Achy	***	Burning	XXX	Weak	###
Pins & needles	OOO	Shooting	$$$	Sharp	///		

FRONT



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