Dynamic Chiropractic & Wellness Center

Patient Name: _____**Date**_____

Please describe your present complaints:_____

When did your problem begin? (specific date) _____

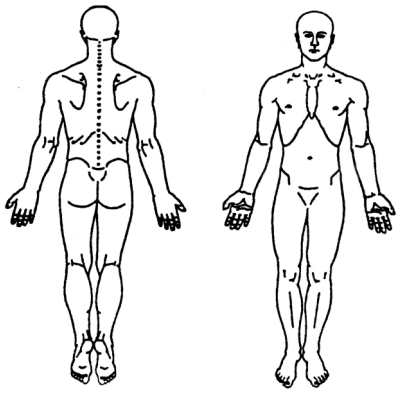
How did your problem begin? (circle one) Gradually Developed Auto Accident Work related injury

Immediately after specific incident After Multiple Incidents

Describe how your problem began: _____

_____

Please circle the character of your current pain: (you may circle more than one): Sharp Stabbing Dull Aching Soreness Stiffness Weakness Throbbing Numbness Shooting Burning Tingling



Please rate the degree of your pain: (Circle the most appropriate)

No pain 0 1 2 3 4 5 6 7 8 9 10 unbearable

How often are your symptoms present: Constant Frequent Occasional Intermittent

Since your problem began, is the pain? Increasing Decreasing No Change

Please circle all activities that make symptoms BETTER: Sitting Standing Laying down

Movement/Exercise Sleep/rest Other (describe) _____

Please circle all activities that make symptoms worse: Sitting Standing Coughing/Sneezing Movement/Exercise Sleep/Rest Other (describe) _____

Have you seen any other providers for this present condition? Yes No

Date Name of Doctor Location Xrays taken?

_____

_____

Past Surgeries/ Broken or Fractured bones/ Year _____

_____

Any past Motor Vehicle Accidents/ Year _____

Please list any medication your are currently taking (include pain killers):

Medication Condition Prescribing Doctor

_____

_____

Please list all vitamins or supplements that you are currently taking;_____

_____

Date of last Physical exam: _____Where: _____Whom?_____

WOMEN: Are you pregnant? Yes No **If yes, due date _____ Are you nursing? Yes No**

PERSONAL HABITS

Do you drink alcohol? Yes No Approximate drinks per week ____

Do your drink caffeine? Yes No Cups per day ____ Primary Source Coffee Soda Tea

Describe your diet: Vegetarian Good Average Bad Do you exercise? Yes No How Often _____

How many hours of sleep do you average a night? ____ Type of Sleep: wake up often or sleep soundly

Do you smoke? Yes No If yes, how long? _____ Packs/ Day _____ Do you use chewing tobacco? Yes No

How would you describe your lifestyle: High stress Average Low stress

FAMILY HISTORY

	Mom	Dad	Sibling	children	Maternal Grandparent	Paternal Grandparent
Arthritis Type:_____	☐	☐	☐	☐	☐	☐
Cancer Type:_____	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
High Blood pressure/Stroke	☐	☐	☐	☐	☐	☐

HEALTH HISTORY CHECK LIST (Past or Present)

Past	Present		Past	Present	
☐	☐	Allergies/Asthma/ Breathing	☐	☐	High Blood Pressure
☐	☐	Arthritis/ Stiffness/ Swelling Jts.	☐	☐	High Cholesterol
☐	☐	Neck Pain/Headaches/Jaw Pain	☐	☐	Heart Disease/Attack/Stroke
☐	☐	Hand/ Wrist/Elbow/Shoulder Pain	☐	☐	Dizziness/Balance/Ear Pain/Ringing
☐	☐	Mid Back Pain/ Low back Pain	☐	☐	Weight Gain/Weight Loss
☐	☐	Hip/knee/ankle/foot pain	☐	☐	Diabetes
☐	☐	Chest Pain	☐	☐	Stomach/Digestive Problems
☐	☐	Numbness/ Tingling where _____	☐	☐	Kidney/ Urinary Problems
☐	☐	Joint Replacement _____	☐	☐	Anxiety/ Depression
☐	☐	Cancer Type _____	☐	☐	Infectious Disease/HIV/AIDS
☐	☐	Alcohol/ Drug Abuse			