



Diet (Do you eat healthy foods)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been in accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had organs replaced/removed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have teeth problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have eye problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have sleeping problems (nightmares)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have occupational stress?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have physical stress?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have mental stress?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have hobbies/sports injuries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleeping Postures (Side / Stomach / Back):	_____	_____	_____	_____	_____	_____

**Current Health Condition** – Brief explanation / reason for your visit today - Present Complaint(s)

Major: \_\_\_\_\_

Pain or Problem started on: \_\_\_\_\_

Pains are:     Sharp     Dull     Constant     Intermittent

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is condition worse during certain times of the day? \_\_\_\_\_

Is this condition interfering with:     Work     Sleep     Routine     Other: \_\_\_\_\_

Is this condition getting progressively worse? \_\_\_\_\_

What other doctors have been seen for this condition? \_\_\_\_\_

Any home remedies? \_\_\_\_\_

If female, are you pregnant? \_\_\_\_\_

**Other symptoms:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Face Flushed           | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Feet Cold       |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Neck Stiff             | <input type="checkbox"/> Loss of Memory     | <input type="checkbox"/> Hands Cold      |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Ears Ring          | <input type="checkbox"/> Stomach Upset   |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fever              | <input type="checkbox"/> Constipation    |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Numbness in Toes       | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Buzzing in Ear  |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Loss of Smell      |  |
| <input type="checkbox"/> Chest Pains       | <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Loss of Taste      |  |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Depression             | <input type="checkbox"/> Diarrhea           |  |

Have you been under drug and medical care? \_\_\_\_\_

What medications are you taking? \_\_\_\_\_ How Long? \_\_\_\_\_

Have you had Surgery? \_\_\_\_\_ What? \_\_\_\_\_ When? \_\_\_\_\_

What side effects, if any, have you experienced from the drugs and surgery? \_\_\_\_\_

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Upon the completion of your visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

**As a result of my chiropractic care, I would like to (check all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> Feel better quickly    | <input type="checkbox"/> Have a healthier body by keeping my nervous system healthy |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Live a healthier lifestyle                                 |

On a Scale of 1-10, how committed are you to your health? (Please Circle):    1   2   3   4   5   6   7   8   9   10

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date