Weum Chiropractic

First Name _____ ***Middle Initial***____ ***Last Name***_____

Address_____ ***City/State***_____ ***Zip***_____

Home Phone_____ ***Work Phone***_____ ***Cell Phone***_____

Best number to reach you at_____ ***Employer/Occupation***_____

Email Address_____ ***Can we send you 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. **What is your #1 complaint for today's visit?** **Rate your pain using a scale from 0-10 (10 being the worst)**
_____ **0 1 2 3 4 5 6 7 8 9 10**
What is your #2 complaint for today's visit?
_____ **0 1 2 3 4 5 6 7 8 9 10**
What is your #3 complaint for today's visit?
_____ **0 1 2 3 4 5 6 7 8 9 10**
What is your #4 complaint for today's visit?
_____ **0 1 2 3 4 5 6 7 8 9 10**

3. **How often do you experience your symptoms for the #1 complaint?**
□ 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 of the #1 complaint?**
□ 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. **How much has the problem interfered with your work and/or social activities?**
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

7. **Who else have you seen for this problem?**_____
8. **How long have you had this problem?** _____yrs. _____mths. _____wks. _____days
9. **How do you think this problem began?** _____
10. **Do you consider this problem to be severe?** □ Yes □ Yes, at times □ No
11. **What makes the problem worse?** _____
12. **What makes the problem better?** _____
13. **What concerns you the most about this problem; What does it prevent you from doing?**_____

14. **How would you rate your overall health?**

□ Excellent □ Very Good □ Good □Fair □Poor

15. **What type of exercise do you do?**

□ Strenuous □ Moderate □Light □ None

16. **Indicate if you have any immediate family members with any of the following:**

□ Rheumatoid Arthritis □ Diabetes □ Lupus

□ Heart Problems □ Cancer □ ALS

17. ***"Past" if you've had the condition in the past; "Present" if you presently have a condition listed.***

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	Chronic Sinusitis	□	□	Dizziness
□	□	Neck Pain	□	□	High Blood Pressure	□	□	Diabetes
□	□	Upper Back Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Mid Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Low Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Shoulder Pain	□	□	Angina	□	□	Drug/Alcohol Dependence
□	□	Elbow/Upper Arm Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Wrist Pain	□	□	Bladder Infections	□	□	Depression
□	□	Hand Pain	□	□	Painful Urination	□	□	Systemic Lupus
□	□	Hip Pain	□	□	Abnormal Weight Gain/Loss	□	□	Epilepsy
□	□	Upper Leg Pain	□	□	Loss of Appetite	□	□	Dermatitis/Eczema/Rash
□	□	Knee Pain	□	□	Abdominal Pain	□	□	HIV AIDS
□	□	Ankle/Foot Pain	□	□	Ulcer	**For Females Only**		
□	□	Jaw Pain	□	□	Liver/Gallbladder Disorder	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	General Fatigue	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Visual Disturbances	□	□	Pregnancy
□	□	Cancer				~~Due Date: _____		
□	□	Asthma						

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

_____

19. **What activities do you do at work?**

Sit:	□ Most of the day	□ Half the day	□ A Little of the day
Stand:	□ Most of the day	□ Half the day	□ A Little of the day
Computer Work:	□ Most of the day	□ Half the day	□ A Little of the day
On the Phone:	□ Most of the day	□ Half the day	□ A Little of the day
Drives:	□ Most of the day	□ Half the day	□ A Little of the day

□ Performs manual labor □ Reads a lot □ Travels frequently

20. **What activities do you do outside of work?** _____

21. **Have you ever been hospitalized?** □ No □ Yes; Why? _____

22. **Have you seen a chiropractor before?** □ No □ Yes If yes, when & where?_____

How was your previous chiropractic experience? _____

23. **Have you had significant past trauma?** □ No □ Yes, _____

24. **Anything else pertinent to your visit today?** _____

Patient Signature_____