# Skadsem Weum Chiropractic

***First Name _____Middle Initial____ Last Name_____***

***Address_____ City/State_____ Zip_____***

***Home Phone_____ Work Phone_____ Cell Phone_____***

***Best number to reach you at_____ Do you prefer reminder calls or texts?***

***Email Address_____ Can we send you monthly health tips/info? ___Y ___N***

***Date of Birth_____ Social Security #_____***

***Spouse name_____***

***Children (name/age)_____***

***How did you hear about our office?_____***

***Employer_____ Occupation_____***

**1. Is today's problem caused by:**

☐ Auto Accident (See Auto Accident form) ☐ Workman's Compensation (See Workman's Compensation form) ☐ Other

**2. When did this problem begin? ___/___/_____**

**3. Briefly describe how this problem began?**

_____

_____

**4. 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**

**5. 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)

**6. How would you describe the type of pain of the #1 complaint?**

☐ Achy ☐ Pinching ☐ Shooting ☐ Throbbing
☐ Burning ☐ Pulling ☐ Sore ☐ Tingling
☐ Dull ☐ Radiating ☐ Stabbing ☐ Other:_____
☐ Numb ☐ Sharp ☐ Stiff

**7. List any tests, studies or medications received for this condition:**

Tests/studies:_____
Xrays/Imaging:_____
Treatments:_____

**8. How are your symptoms changing with time?**

☐ Getting worse ☐ Staying the same ☐ Getting better

**9. What makes the problem worse?**

_____

**10. What makes the problem better?**

_____

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

| Past | Present | | Past | Present | |
|---|---|---|---|---|---|
| ☐ | ☐ | Abdominal Pain | ☐ | ☐ | Headaches |
| ☐ | ☐ | Abnormal Weight Gain/Loss | ☐ | ☐ | Migraines |
| ☐ | ☐ | Alcohol/Drug Dependence | ☐ | ☐ | Heart attack |
| ☐ | ☐ | Allergies | ☐ | ☐ | Jaw Pain |
| ☐ | ☐ | Angina | ☐ | ☐ | Joint stiffness |
| ☐ | ☐ | Ankle Pain | ☐ | ☐ | Knee Pain |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Kidney Stones |
| ☐ | ☐ | Asthma | ☐ | ☐ | Loss of Appetite |
| ☐ | ☐ | Bladder Infection | ☐ | ☐ | Low Back Pain |
| ☐ | ☐ | Cancer | ☐ | ☐ | Mid Back Pain |
| ☐ | ☐ | Chest Pains | ☐ | ☐ | Migraines |
| ☐ | ☐ | Chronic Pain | ☐ | ☐ | Neck Pain |
| ☐ | ☐ | Depression | ☐ | ☐ | Painful Urination |
| ☐ | ☐ | Dermatitis/Eczema | ☐ | ☐ | Shoulder Pain |
| ☐ | ☐ | Dizziness | ☐ | ☐ | Stroke |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Lupus |
| ☐ | ☐ | Ear Infection | ☐ | ☐ | Upper Back Pain |
| ☐ | ☐ | Elbow Pain | ☐ | ☐ | Urinary Tract Infection |
| ☐ | ☐ | Epilepsy | ☐ | ☐ | Visual Disturbances |
| ☐ | ☐ | Excessive Thirst | ☐ | ☐ | Wrist Pain |
| ☐ | ☐ | Fatigue | **For Female Only:** | | |
| ☐ | ☐ | Frequent Urination | ☐ | ☐ | Birth Control |
| ☐ | ☐ | Hand Pain | ☐ | ☐ | Hormonal Replacement |
| ☐ | ☐ | Leg Pain | ☐ | ☐ | Pregnancy (Due:_____) |
| ☐ | ☐ | Hand Pain | | | |

**12. Do you suffer from any condition other than that for which you are now**

**consulting us?** ☐No ☐Yes_____

| **13. Family History:** | **Diabetes** | **Cancer** | **Back Pain** | **Other** |
|---|---|---|---|---|
| **Mother** | ☐ | ☐ | ☐ | ☐_____ |
| **Father** | ☐ | ☐ | ☐ | ☐_____ |
| **Brother(s)** | ☐ | ☐ | ☐ | ☐_____ |
| **Sister(s)** | ☐ | ☐ | ☐ | ☐_____ |

**14. Smoking** Packs/day:___ **Alcohol** Cups/day:___**Coffee** Cups/day:___
**Soft Drink** Cans/day:___ **Water** Cups/day:___

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

_____

**16. List all vitamins/supplements you are currently taking:**

_____

**17. Do you have allergies?** ☐No ☐Yes,

_____

**18. Have you ever had any surgeries/hospitalizations/traumas?** ☐No ☐Yes (If yes, for what and when)

_____

**19. Have you seen a chiropractor before?** ☐ No ☐ Yes If yes, when & where?

_____

How was your previous chiropractic experience?

_____

Patient Signature_____ Date:_____