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

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		Past	Present	
□	□	Abdominal Pain	□	□	Elbow Pain	□	□	Mid Back Pain
□	□	Abnormal Weight gain/loss	□	□	Epilepsy	□	□	Migraines
□	□	Allergies	□	□	Excessive Thirst	□	□	Neck Pain
□	□	Angina	□	□	Fainting	□	□	Painful Urination
□	□	Ankle Pain	□	□	Fatigue	□	□	Shoulder Pain
□	□	Arthritis	□	□	Frequent Urination	□	□	Stroke
□	□	Asthma	□	□	Hand Pain	□	□	Upper Arm Pain
□	□	Bladder Infections	□	□	Headaches	□	□	Upper Back Pain
□	□	Cancer	□	□	Heart Attack	□	□	Visual Disturbances
□	□	Chest Pain	□	□	Jaw Pain	□	□	Wrist Pain
□	□	Chronic Pain	□	□	Joint Stiffness	**For Females Only**		
□	□	Depression	□	□	Knee Pain	□	□	Birth Control Pills
□	□	Dermatitis/Eczema	□	□	Kidney Stones	□	□	Hormonal Replacement
□	□	Diabetes	□	□	Loss of Appetite	□	□	Pregnancy
□	□	Dizziness	□	□	Leg Pain	Due:_____		
□	□	Ear Infections	□	□	Low Back 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:_____