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

□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Heart Problems □ Cancer □ ALS

19. For each of the following conditions, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

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

20. List all prescription medications you are currently taking:

_____

21. List all of the over-the-counter medications you are currently taking:

_____

22. List all surgical procedures you have had:

_____

23. 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 of the day	□ A little of the day

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? □ No □ Yes If yes, why_____

_____

26. Have you had significant past Injures / trauma? □ No □ Yes _____

_____

27. Anything else pertinent to your visit today?_____

_____

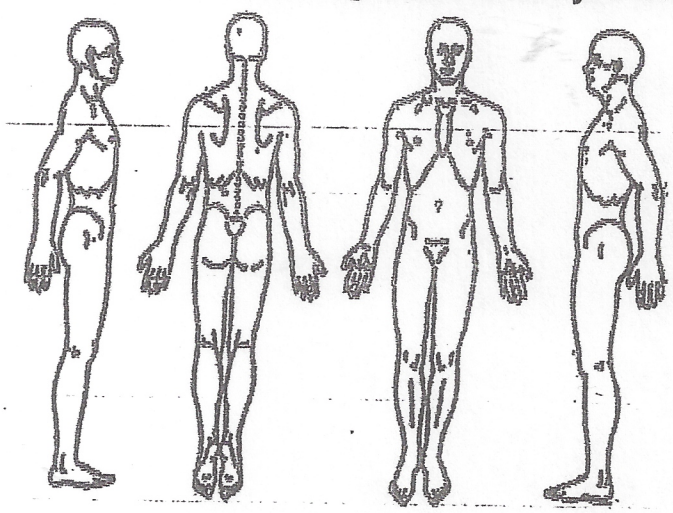
Patient Signature_____ **Date:**_____

CONFIDENTIAL PATIENT INFORMATION

Patient Name :(First)_____ (M.I)___ (Last)_____ Date: ___/___/____
Title: □ Mr. □ Mrs. □ Miss □ Ms. □ Dr □ Other:_____ Nickname:_____
Address:_____ City:_____ St._____ Zip_____
SS#:____/____/_____ Gender: □ M □ F Marital status: □S □M □D □W □Separated
Date of Birth: ____/___/_____ Age:____ Spouse Name:_____
Phone:(Home)_____ (Cell)_____ (Work)_____
Email_____ Emergency contact: Name:_____
Relationship:_____ Phone #_____
Will Payment Be: □ Self Pay □ Insurance □ Medicare
REFERRED BY: Google □ Yelp □ Other _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation Injury □ Other

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?
- □ 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?
- □ Sharp
- □ Dull
- □ Diffuse
- □ Achy
- □ Burning
- □ Shooting
- □ Stiff
- □ Numb
- □ Tingly
- □ Sharp with motion
- □ Shooting with motion
- □ Stabbing with motion
- □ Electric like with motion
- □ Other:_____

5. How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem? □Chiropractor □Neurologist □Primary Care Physician
□ER physician □Orthopedist □Massage Therapist □Physical Therapist □No one □Other:_____

10. How long have you had this problem? _____

11. How do you think your problem began? _____

12. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

13. What aggravates your problem? _____

14. What concerns you the most about your problem; what does it prevent you from doing?
_____

15. What is your: Height_____ Weight _____Date of Birth _____Occupation _____

16. How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None