

IN ORDER TO COMPLETELY AND SAFELY SERVE YOUR NEEDS, WE ASK THAT YOU COMPLETE THIS FORM. THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL IN YOUR RECORD/CHART.

Today's date: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ MALE/FEMALE

What areas of the body (e.g. left shoulder, right knee, etc.) are you currently seeking treatment for? Which (if more than one area) is the most problematic at this time? Have you ever been treated for this same problem before? Where (what clinic)?

During the past year, have you been treated by any of the following (please circle)? If so, please elaborate below: MD Chiropractor Neurologist Psychiatrist/Psychologist Osteopath

Please list all relevant surgeries you have had in the past, including reason and approximate date/year.

Have you ever had any Cortisone/Epidural or other injections? Please state when, how many and in which body areas.

Do you currently have, or have had a HISTORY of: Please circle all that apply or list any not currently listed.

- |                              |                             |   |                        |
|------------------------------|-----------------------------|---|------------------------|
| Heart/Cardiovascular Disease | Asthma/difficulty Breathing | Hepatitis/Liver Disease                               | Depression             |
| High Blood Pressure          | Congestive Heart Failure    | Epilepsy/Seizures                                     | Anemia                 |
| Diabetes-Type I or II        | Multiple Sclerosis          | Thyroid Condition                                     | Osteoporosis/Fractures |
| Stroke                       | Fibromyalgia                | Neurological Condition                                | Chronic Infections     |
| Rheumatoid Arthritis         | Migraines/Headaches         | Eating Disorders                                      | Lupus                  |
| Kidney/Renal Disease         | Osteoarthritis              | Vestibular disorder / Fainting Spells                 |                        |
| Drug or Alcohol abuse        | Hearing Problems            | Circulatory Disorder / Poor Circulation / Blood Clots |                        |
| Smoking / Tobacco Use        | High Cholesterol            | Other _____   |                        |

Heart Problems (Describe) \_\_\_\_\_

Cancer \_\_\_\_\_ Location \_\_\_\_\_ Year \_\_\_\_\_

Do you currently have a/ or are you experiencing: (Circle all those that apply to you)

- |                        |                                |                   |                     |
|------------------------|--------------------------------|-------------------|---------------------|
| Pacemaker              | Fatigue                        | Chest pain        | Dizziness           |
| Internal defibrillator | Loss of bowel/bladder function | Numbness/tingling | Fever/chills/sweats |
| Insulin pump           | Weakness                       | Nausea/vomiting   |                     |
- Other implanted medical devices? What \_\_\_\_\_

FOR WOMEN: Are you considering becoming or are you currently pregnant? Yes No

Please list all over the counter and prescription medication you are presently taking and reason for medication (i.e. Accupril for Blood Pressure, Prozac for Depression). (Include: pills, injections, skin patches)

Do you exercise regularly? How often and what activities? Do you play any sports?

I CERTIFY TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS COMPLETE AND TRUE.

Signature (parent or guardian if under 18 years of age)

Today's date

\*Please bring this form with you on the date of your initial appointment!