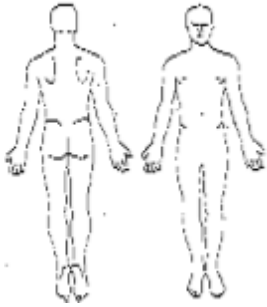


Full Name _____ Date _____

The symptoms that have prompted me to seek care today include: _____

They are the result of: An accident or injury
 Work Auto Other _____
 A worsening long-term problem

1) LOCATION (Where does it hurt?)
Circle the area(s) on the illustration



2) QUALITY OF SYMPTOMS
(What does it feel like?)

- Numbness
- Tingling
- Stiff/Tight
- Dull
- Aching/Sore
- Nagging
- Sharp
- Shooting
- Throbbing
- Stabbing
- Other

3) INTENSITY (How extreme are your current symptoms?)
best **0 1 2 3 4 5 6 7 8 9 10** worst

4) PAIN/DISCOMFORT LEVEL: Mild Moderate Severe

5) DURATION AND TIMING: (How often do you feel it?)
 Occasional Intermittent Frequent Constant

6) RADIATION (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

7) AGGRAVATING/RELIEVING FACTORS:

What makes it worse? _____
 What makes it better? _____

8) PRIOR INTERVENTIONS

(What have you done to relieve the symptoms?)

- Medical Doctor/ER Surgery Ice Homeopathic remedies Chiropractic Over the Counter Meds
- Prescription Meds Acupuncture Heat Physical Therapy Massage Other

9) REVIEW OF SYSTEMS (Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please mark the circle beside any condition that you've **Had** or currently **Have** and initial to the right.)

a. Musculoskeletal System

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	None <input type="radio"/>
<input type="radio"/> Osteoporosis	<input type="radio"/> Arthritis	<input type="radio"/> Scoliosis	<input type="radio"/> Neck Pain	<input type="radio"/> Back Problems	<input type="radio"/> Hip Disorders	Initials _____
<input type="radio"/> Knee Injuries	<input type="radio"/> Foot/Ankle Pain	<input type="radio"/> Shoulder Problems	<input type="radio"/> Elbow/wrist pain	<input type="radio"/> TMJ issues	<input type="radio"/> Poor Posture	

b. Neurological System

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	None <input type="radio"/>
<input type="radio"/> Anxiety	<input type="radio"/> Depression	<input type="radio"/> Headache	<input type="radio"/> Dizziness/ Balance	<input type="radio"/> Pins and needles	<input type="radio"/> Numbness	Initials _____

c. Cardiovascular System

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	None <input type="radio"/>
<input type="radio"/> High Blood Pressure	<input type="radio"/> Low Blood Pressure	<input type="radio"/> High Cholesterol	<input type="radio"/> Poor Circulation	<input type="radio"/> Angina	<input type="radio"/> Excessive Bruising	Initials _____

d. Respiratory System

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	None <input type="radio"/>
<input type="radio"/> Asthma	<input type="radio"/> Apnea	<input type="radio"/> Emphysema	<input type="radio"/> Hay Fever	<input type="radio"/> Shortness of Breath	<input type="radio"/> Pneumonia	Initials _____

e. Digestive System

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	None <input type="radio"/>
<input type="radio"/> Anorexia/ Bulimia	<input type="radio"/> Ulcer	<input type="radio"/> Food sensitivities	<input type="radio"/> Heartburn	<input type="radio"/> Constipation	<input type="radio"/> Diarrhea	Initials _____

f. Sensory System

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	None <input type="radio"/>
<input type="radio"/> Blurred Vision	<input type="radio"/> Ringing in Ears	<input type="radio"/> Hearing Loss	<input type="radio"/> Chronic ear Infections	<input type="radio"/> Loss of smell	<input type="radio"/> Loss of taste	Initials _____

Name _____

g. Skin System

- | | | | | | | |
|---|---|--|--|---|--|----------------|
| Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None O |
| <input type="checkbox"/> <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> <input type="checkbox"/> Psoriasis | <input type="checkbox"/> <input type="checkbox"/> Eczema | <input type="checkbox"/> <input type="checkbox"/> Acne | <input type="checkbox"/> <input type="checkbox"/> Hair loss | <input type="checkbox"/> <input type="checkbox"/> Rash | Initials _____ |

h. Endocrine System

- | | | | | | | |
|--|--|--|--|--|--|----------------|
| Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None O |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid issues | <input type="checkbox"/> <input type="checkbox"/> Immune disorders | <input type="checkbox"/> <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> <input type="checkbox"/> Frequent infection | <input type="checkbox"/> <input type="checkbox"/> Swollen glands | <input type="checkbox"/> <input type="checkbox"/> Low energy | Initials _____ |

i. Genitourinary System

- | | | | | | | |
|---|---|--|---|--|--|----------------|
| Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None O |
| <input type="checkbox"/> <input type="checkbox"/> Kidney stones | <input type="checkbox"/> <input type="checkbox"/> Infertility | <input type="checkbox"/> <input type="checkbox"/> Bedwetting | <input type="checkbox"/> <input type="checkbox"/> Prostate issues | <input type="checkbox"/> <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> <input type="checkbox"/> PMS symptoms | Initials _____ |

j. Constitutional System

- | | | | | | | |
|--|--|---|---|---|--|----------------|
| Had Have | Had Have | Had Have | Had Have | Had Have | Had Have | None O |
| <input type="checkbox"/> <input type="checkbox"/> Fainting | <input type="checkbox"/> <input type="checkbox"/> Low Libido | <input type="checkbox"/> <input type="checkbox"/> Poor appetite | <input type="checkbox"/> <input type="checkbox"/> Fatigue | <input type="checkbox"/> <input type="checkbox"/> Sudden weight gain/loss | <input type="checkbox"/> <input type="checkbox"/> Weakness | Initials _____ |

PAST PERSONAL, FAMILY AND SOCIAL HISTORY (Please identify your past health history, including accidents, injuries, illnesses and treatments.) Please complete each section fully.

10) ILLNESSES (Identify the illnesses you have **HAD** in the past or **HAVE** now.)

- | | | | | | |
|---|---|--|---|--|--|
| Had Have | Had Have | Had Have | Had Have | Had Have | Had Have |
| <input type="checkbox"/> <input type="checkbox"/> AIDS | <input type="checkbox"/> <input type="checkbox"/> Alcoholism | <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> <input type="checkbox"/> Goiter | <input type="checkbox"/> <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Gout | <input type="checkbox"/> <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> HIV Positive | <input type="checkbox"/> <input type="checkbox"/> Malaria | <input type="checkbox"/> <input type="checkbox"/> Measles | <input type="checkbox"/> <input type="checkbox"/> Mumps | <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> <input type="checkbox"/> Polio | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> <input type="checkbox"/> STDs | <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> <input type="checkbox"/> Ulcer | <input type="checkbox"/> <input type="checkbox"/> Allergies (list) _____ | | | |

11) INJURIES Have you ever... (Please indicate date or age of occurrence)

- | | |
|--|---|
| <input type="checkbox"/> Had a fractured or broken bone? Explain _____ | <input type="checkbox"/> Had a spine or nerve disorder? Explain _____ |
| <input type="checkbox"/> Been knocked unconscious? _____ | <input type="checkbox"/> Been injured in an accident? _____ |
| <input type="checkbox"/> Used a crutch or other support? _____ | <input type="checkbox"/> Used neck or back bracing? _____ |
| <input type="checkbox"/> Received a tattoo? _____ | <input type="checkbox"/> Had a body piercing? _____ |

12) OPERATIONS (Surgical interventions, which may or may not have included hospitalization) Please include date of surgery

- | | | |
|--|---|--|
| <input type="checkbox"/> Appendectomy - date _____ | <input type="checkbox"/> Bypass surgery - date _____ | <input type="checkbox"/> Hysterectomy - date _____ |
| <input type="checkbox"/> Pacemaker date _____ | <input type="checkbox"/> Tonsillectomy - date _____ | <input type="checkbox"/> Vasectomy - date _____ |
| <input type="checkbox"/> Cancer - date _____ type _____ | <input type="checkbox"/> Cosmetic surgery - date _____ type _____ | |
| <input type="checkbox"/> Spine surgery - date _____ type _____ | | |
| <input type="checkbox"/> Other - date _____ explain _____ | | |

13) MEDICATIONS (Please list ALL prescriptions and over-the-counter):

14) FAMILY HISTORY Some health issues are hereditary. Tell Dr. Miller about the health of your family members.

Relative	Illnesses	Age at death	Cause of death	
			Natural	Illness
Mother	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Father	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Brother	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Sister	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Maternal G-mother	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Paternal G-mother	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Maternal G-father	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Paternal G-father	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

15) OCCUPATIONAL HISTORY: Occupation _____

Full Time Part Time Retired

16) SOCIAL HISTORY (Tell Dr. Miller about your health habits and stress levels.)

Alcohol use Daily Weekly How much? _____
Coffee use Daily Weekly How much? _____
Tobacco Use Daily Weekly How much? _____
Exercising Daily Weekly How much? _____
Pain Relievers Daily Weekly How much? _____
Soft Drinks Daily Weekly How much? _____
Water Intake Daily Weekly How much? _____

Home pressures/stress? Yes No
Job pressures/stress? Yes No
Former smoker? Yes No
Trying to quit Yes No
Need info to help quit Yes No
Recreational Drugs? Yes No
Hobbies: _____

17) How much sleep do you average per night? _____ Hours

ACKNOWLEDGEMENTS: To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement after each statement.

I instruct the chiropractor to deliver the care that, in her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity. *Initials* _____

I have signed the privacy policy and been offered a copy. I understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. *Initials* _____

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office. *Initials* _____

I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for the payment of any covered or non-covered services I receive. *Initials* _____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. *Initials* _____

If the patient is a minor child, print child's full name: _____

Signature

Date

PHQ 3/3