Id# ________ **C… l Chiropractic's Health P… le** **Date:** ________

As a full spectrum chiropractic office, foc… n your ability to be healthy. Our … a… rst, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stressors that can accumulate and interfere with the proper function of our neuromuscular system. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced and allow us to better assess the challenges to your health potential. Please answer the following questions to the best of your ability. For insurance billing purposes, services must be considered medically necessary.

Name: ________ Birthdate: ________ Age: ______ Height: ______ Weight: ______
Address: ________ Home Phone: ________ Work Phone: ________
City: ________ State: ____ Zip: ______ Cell Phone: ________ Email: ________

Who may we thank for referring you to our office? ________
Have you ever received Chiropractic Care? Yes / No If yes, why? ________
When? ________ Where? ________ Were the results satisfactory? Yes / No ________

Reasons for seeking Chiropractic Care in our office:

Primary reason: ________ Secondary reason: ________

What caused this condition? When? ________

What positions or activities aggravate this condition? ________

What positions or activities relieve this condition? ________

How has this condition affected your work or function? ________

Have you had similar symptoms in the past? When? ________

Who else in your family has this same or similar problem? ________

Is this problem getting ☐better ☐worse ☐not changing? How does it make you feel? ________

DURATION: Symptoms started: ___/___/___ Symptoms worsened: ___/___/___ Symptoms last occurred: ___/___/___

BODY AREA INVOLVED: ☐ Head/Neck ☐ Spine/Ribs/Pelvis ☐ Upper Extremity L/R ☐ Lower Extremity L/R
CHIEF COMPLAINT: ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness
CONDTION TYPE: ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic

QUALITY: ☐Localized ☐ General ☐Dull/Aching ☐Sharp ☐Burning ☐Shooting ☐Stabbing ☐Tingling ☐Radiating ☐Throbbing ☐Tightness ☐Deep ☐Other ________

FREQUENCY: ☐Occasional (0-25%) ☐Frequent (26-50%) ☐Intermittent (51-75%) ☐Constant (76-100%)
TIMING: ☐Worse AM ☐Worse PM ☐Worse with Activity ☐Worse with Rest
SEVERITY: ☐Minimal ☐Mild ☐Mild/Moderate ☐Moderate ☐Moderate/Severe ☐Severe

ASSOCIATED SIGNS AND SYMPTOMS:
☐ Fever ☐Swelling ☐Spasm ☐Tenderness ☐Dizziness ☐Nausea ☐Fatigue ☐Irritability ☐Restricted Movement
☐Weakness – Location ________ ☐Radiation – Location ________

HEADACHE:
Location: ☐Back of Head ☐Forehead Area ☐Temple Area ☐Above the Ears ☐Top of Head ☐Sinus
Quality: ☐Dull ☐Sharp ☐Throbbing ☐Stabbing ☐Aura ☐No Aura
Types: ☐Hat Band ☐Cluster ☐Migraine ☐Tension ☐ Light sensitive ☐ Noise sensitive

What diagnostic tests have you had for this condition and when were they performed?
☐ X-rays/Date: ______ ☐ MRI/date: ______ ☐ CT scan/date: ______ ☐ Other/date: ______

List any interventions, treatments, medications, surgery or care you've sought for this condition: ________
____

EMPLOYMENT:

Occupation: ______________________ Work Hours Per Day: __________ Night: __________

Level of Education: ☐High school ☐Some college ☐College graduate ☐Post graduate studies ☐Doctorate

Job Classification: ☐Sedentary(0-10lbs) ☐Light(10-20lbs) ☐Medium(20-50lbs) ☐Heavy(50-100lbs) ☐Very Heavy(>100lbs)

Lifting Frequency: ☐ Occasional (0-33%) ☐Frequent (33-66%) ☐ Constant (66-100%)

Lifting Postures: ☐Floor to Waist ☐Waist to Shoulder ☐Shoulder to Above Head

Job Dissatisfaction: ☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

Condition's Effect on Work Activities: ☐No Effect ☐Painful (can do) ☐Painful (limits) ☐Unable to Perform

Explain how? ______________________

SOCIAL HISTORY QUESTIONNAIRE:

Condition effects your family?	☐Not at all	☐A little bit	☐Moderately	☐Quite a bit	☐Extremely
Condition effects your self-esteem?	☐Not at all	☐A little bit	☐Moderately	☐Quite a bit	☐Extremely
Condition effects your social activities?	☐Not at all	☐A little bit	☐Moderately	☐Quite a bit	☐Extremely
Condition effects your recreational activities?	☐Not at all	☐A little bit	☐Moderately	☐Quite a bit	☐Extremely

Explain how? ______________________

Rate your level of Function at its worst (0 is no loss of function; 10 is severe loss of function)

Level of Function affected by discomfort (Resting): 0 1 2 3 4 5 6 7 8 9 10

Level of Function affected by discomfort (With Activity): 0 1 2 3 4 5 6 7 8 9 10

Symptoms Better With: ☐Activity ☐Rest ☐Ice ☐Heat ☐Weather ☐Exercising ☐Sleeping ☐Walking ☐ Massage ☐Stretching ☐Prescription Medicines ☐Sitting ☐Standing ☐Kneeling ☐Over the Counter Medicines

Present Lifestyle Information/ Comments:

Activity Levels: ☐Sedentary/ Inactive
☐Lifestyle-Necessary (No Structured Exercise)
☐Occasional/ Recreational (No Regular Structured Exercise)
☐Regular & Active (Participates in Regular Exercise)

Please specify ______________________

Dietary Habits: ☐Unconscious eating
☐Have dietary awareness but doesn't practice nutritious eating
☐Have dietary awareness & practices healthy eating habits ☐sometimes ☐most times
☐Take nutritional supplements and vitamins

Please specify ______________________

Stress Level: On a scale of 1-10, 10 being the highest, please describe your level of stress:

Occupational ______ Personal _______ Physical ________ Medical ________ Chemical ________

Present Sleeping Habits Per Night:	☐4-6 hours	☐ 6-8 hours	☐8-10 hours	☐10-12 hours
	☐Back	☐Side	☐Stomach	☐ All
	☐Poor	☐Fair	☐Good	☐Excellent
Present water intake per day:	☐0-3 cups	☐4-6 cups	☐ 7-9 cups	☐10-12 cups
Present posture:	☐Poor	☐Fair	☐Good	☐Excellent
Present health:	☐Poor	☐Fair	☐Good	☐Excellent

What activities would you like to be doing again as a result of your treatment? ______________________

List any concerns that could interfere with your commitment? (Time, Transportation, Other) Specify: ______________________

Are you as healthy as you want to be? Yes / No Why? ______________________

I have read the above information and certify it to be true to the best of my knowledge, and hereby authorize Cecil Chiropractic to provide me with chiropractic care, in accordance with the state's statutes.

Patient's Signature: **Date:**