Active Chiropractic & Wellness of Chagrin Falls

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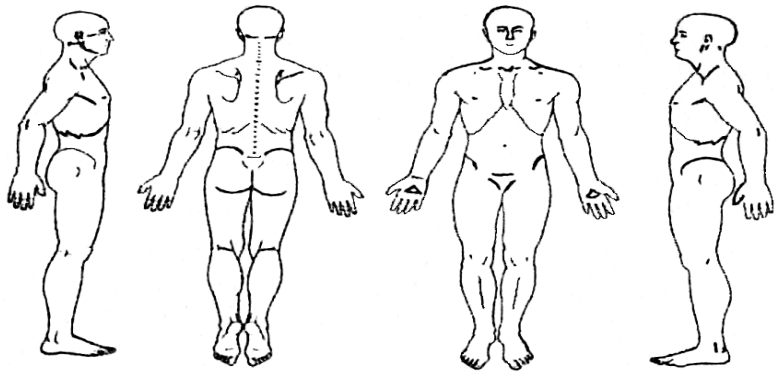
Name: _____ DOB _____ Date: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem (areas experiencing pain/tingling/numbness)	**Severity** Minimal → Severe	**Frequency (% of week)** Occasional → Constant
a. Neck	0 1 2 3 4 5 6 7 8 9 10	0 25 50 75 100
b. Mid-back	0 1 2 3 4 5 6 7 8 9 10	0 25 50 75 100
c. Low-back	0 1 2 3 4 5 6 7 8 9 10	0 25 50 75 100
d. Hips	0 1 2 3 4 5 6 7 8 9 10	0 25 50 75 100
e. Arms	0 1 2 3 4 5 6 7 8 9 10	0 25 50 75 100
f. Legs	0 1 2 3 4 5 6 7 8 9 10	0 25 50 75 100
g.	0 1 2 3 4 5 6 7 8 9 10	0 25 50 75 100
h.	0 1 2 3 4 5 6 7 8 9 10	0 25 50 75 100

2. Condition (**a**.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
3. Condition (**b**.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. PLEASE MARK THE FIGURE WHERE YOU EXPERIENCE SYMPTOMS/PAIN



5. Circle when the symptoms are worse:
   Morning / Afternoon / Night / Increase during the day / Same all day / Decrease during the day
6. When/how did your condition begin (onset date)? _____
7. Have you experienced these before? ☐ No ☐ Yes Describe: _____
8. Do your symptoms extend into your arms or legs?, explain. _____
9. Have you ☐ Improved ☐ Gotten Worse ☐ Stayed the same since it began
10. Circle the things that make your symptoms worse:
    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping
11. Is there anything you can do to relieve the symptoms? ☐ No ☐ Yes Describe: _____
    If No, what have you tried that has not helped? _____
12. What treatment did you receive and when? _____
13. Have you ever been under Chiropractic Care? ☐ No ☐ Yes Doctor's name_____

14. Results of previous treatment? ☐ Good ☐ Poor Describe _____

15. Is this condition interfering with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

16. What is your lack of health preventing you from doing or enjoying?_____

17. Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? ☐ No ☐ Yes If so, Where?_____

18. What operations have you had?_____When?_____

19. Serious illness/infectious diseases:_____

20. Do you have a pace maker? ☐ No ☐ Yes Have you had any Hip or Knee Replacements ☐ No ☐ Yes_____

21. What medications or drugs are you taking? ☐ Pain Killers ☐ Insulin ☐ Cholesterol Meds ☐ Birth Control

☐ Blood Pressure Meds ☐ Muscle Relaxers ☐ Acid Blockers Other: _____

22. List any allergies you have_____

23. Describe your appetite: ☐ Average ☐ Above Average ☐ Below Average

24. What vitamins or minerals are you taking? _____

25. What do you believe is wrong with you? _____

26. What is your goal in our office? _____

27. How many hours of sleep do you get each night? _____

☐ Continuous ☐ Trouble staying asleep ☐ Trouble getting to sleep ☐ Other _____

28. Age of mattress:_____ ☐ Comfortable ☐ Uncomfortable

29. Age of pillow:_____

30. Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

31. Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe:_____

32. Have you ever had any mental or emotional disorders: ☐ No ☐ Yes When? _____

33. HAVE YOU EVER: Describe briefly

Been knocked unconscious? ☐ No ☐ Yes _____

Had a fractured bone? ☐ No ☐ Yes _____

Been hospitalized for other than surgery? ☐ No ☐ Yes _____

FAMILY HEALTH INFORMATION (Many health problems are hereditary; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

Where do you see yourself in 5-10 years if these health conditions are not corrected?_____

_____

_____

What is your present level of commitment to fix the causes of the problems you are having? Rate from 1-10 with 10 being 100% committed. 1 2 3 4 5 6 7 8 9 10

Please check the appropriate box for any symptom you have had.

O – Occasional
F – Frequent
C – Constant

GENERAL

O F C

☐ ☐ ☐ Allergy
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of sleep
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

MUSCLE & JOINT

O F C

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot trouble
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Neck pain or stiffness
☐ ☐ ☐ Pain between shoulder

PAIN OR NUMBNESS IN:

☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet
☐ ☐ ☐ Painful tail bone
☐ ☐ ☐ Poor posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Spinal curvature
☐ ☐ ☐ Swollen joints

GASTRO-INTESTINAL

O F C

☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Colon trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Gall bladder trouble
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Liver trouble
☐ ☐ ☐ Nausea
☐ ☐ ☐ Stomach pain/distension

EYES, EARS, NOSE, THROAT

☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Earache
☐ ☐ ☐ Enlarged glands/thyroid
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Sinus infection
☐ ☐ ☐ Sore throat

SKIN

☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives or itching
☐ ☐ ☐ Skin eruptions (rash)
☐ ☐ ☐ Varicose veins

CARDIO-VASCULAR

O F C

☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid heart beat
☐ ☐ ☐ Slow heart beat
☐ ☐ ☐ Swelling of ankles

RESPIRATORY

☐ ☐ ☐ Chest pain
☐ ☐ ☐ Chronic cough/
☐ ☐ ☐ Difficult breathing/ wheezing
☐ ☐ ☐ Spitting up phlegm

GENITO-URINARY

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Frequent painful urination
☐ ☐ ☐ Inability to control kidneys
☐ ☐ ☐ Kidney infection or stones
☐ ☐ ☐ Prostate trouble

FOR WOMEN ONLY

☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Excess menstrual flow
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Painful menstruation
☐ ☐ ☐ Menopausal symptoms
☐ Yes ☐ No Are you Pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

☐ Alcoholism	☐ Cold sores	☐ Fever blisters	☐ Measles	☐ Rheumatic fever
☐ Anemia	☐ Diabetes	☐ Goiter	☐ Miscarriage	☐ Scarlet fever
☐ Appendicitis	☐ Eczema	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Arthritis	☐ Emphysema	☐ Heart Disease	☐ Mumps	☐ Tuberculosis
☐ Cancer	☐ Epilepsy	☐ HIV/AIDS	☐ Polio	☐ Ulcers

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

Notes_____

_____

_____