



(Please print and fill in form completely)

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

**Reason For Your Visit**

Current health concern: \_\_\_\_\_

Is this concern related to a sports injury, surgical procedure, gradual problem auto or work accident or other? \_\_\_\_\_

When did it begin? \_\_\_\_\_

Describe symptoms: \_\_\_\_\_

Please list your medications, including homeopathics, vitamins, etc. (will make copy of your list if you prefer): \_\_\_\_\_

**Please check any of the following medical or rehabilitative services you have received for this condition:**

- |   |   |  |                                 |                                       |
|---|---|--|---------------------------------|---------------------------------------|
| <input type="checkbox"/> Orthopedist          | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> X-Rays          | <input type="checkbox"/> EMG    | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> CT Scan              | <input type="checkbox"/> Neurologist      | <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> MRI    | <input type="checkbox"/> Injection    |
| <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Cast or Brace    | <input type="checkbox"/> ER Visit        | <input type="checkbox"/> Other: |                                       |

**Please check all conditions that apply:**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Neck Pain              | <input type="checkbox"/> Back Pain              | <input type="checkbox"/> Arm Pain          | <input type="checkbox"/> Leg Pain           | <input type="checkbox"/> Joint Pain       |
| <input type="checkbox"/> Muscle Jerking         | <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Fractures         | <input type="checkbox"/> Weakness           | <input type="checkbox"/> Limited Motion   |
| <input type="checkbox"/> Strains or Sprains     | <input type="checkbox"/> Joint Dislocation      | <input type="checkbox"/> Joint Subluxation | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Disc Problems    |
| <input type="checkbox"/> Metal Implants         | <input type="checkbox"/> Prosthesis             | <input type="checkbox"/> Headaches         | <input type="checkbox"/> Visual Disturbance | <input type="checkbox"/> Dizziness        |
| <input type="checkbox"/> Vertigo                | <input type="checkbox"/> Balance Concerns       | <input type="checkbox"/> Sinus Trouble     | <input type="checkbox"/> Chronic Earaches   | <input type="checkbox"/> Tinnitus         |
| <input type="checkbox"/> Hearing Concerns       | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> COPD/Lung Disease | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Excessive Stress |
| <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Multiple Sclerosis     | <input type="checkbox"/> Fibromyalgia      | <input type="checkbox"/> Parkinson's        | <input type="checkbox"/> Stroke/TIA       |
| <input type="checkbox"/> Numbness/Tingling      | <input type="checkbox"/> Seizures               | <input type="checkbox"/> Paralysis         | <input type="checkbox"/> Thyroid            | <input type="checkbox"/> Poor Appetite    |
| <input type="checkbox"/> Digestive Disorders    | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Hepatitis         | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Bladder Concerns |
| <input type="checkbox"/> Bowel Concerns         | <input type="checkbox"/> Nausea                 | <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Arteriosclerosis |
| <input type="checkbox"/> Hypertension           | <input type="checkbox"/> Anemia/Blood Disorders | <input type="checkbox"/> Pacemaker         | <input type="checkbox"/> Cancer             |   |

Please list any allergies including allergies to medication: \_\_\_\_\_

Please list past surgeries or hospitalizations: \_\_\_\_\_

Please list any significant family history of illness or disease: \_\_\_\_\_

How many hours of sleep do you average per night? \_\_\_\_\_

- |   |     |    |                        |
|---|-----|----|------------------------|
| Do you smoke?   | yes | no | Packs per day: _____   |
| Do you drink alcohol?   | yes | no | Drinks per week: _____ |
| Do you exercise regularly?                                      | yes | no | Days per week: _____   |
| Are you pregnant or think you may be?                           | yes | no |                        |
| Do you have a history of complicated pregnancies or deliveries? | yes | no |                        |

