DESIRED CARE CHIROPRACTIC, PLLC

Last Name:_____ First Name:_____ MI:_____

Address:_____ Apt./Unit:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-mail Address:_____

Height:_____ft_____in. Weight:_____ DOB:_____ Gender: ____Male ____Female

Marital status: _____Single _____Engaged _____Married _____Divorced _____Separated _____Widowed

Occupation:_____ Employer:_____

How were you referred to Desired Care Chiropractic?:_____

Emergency Contact: _____Phone Number:_____ Relationship to patient:_____

Reason for visit:_____

When did the problem begin:_____

How did the problem begin:_____

Is your current condition a result of an auto/work accident? _____

Please describe your current pain.

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting

☐ Burning ☐ Tingling ☐ Other_____

Since your problem began, is the pain…

☐ Increasing ☐ Decreasing ☐ Not Changing

How frequent is your pain?

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

What makes your problem better?

_____

What makes your problem worse?

_____

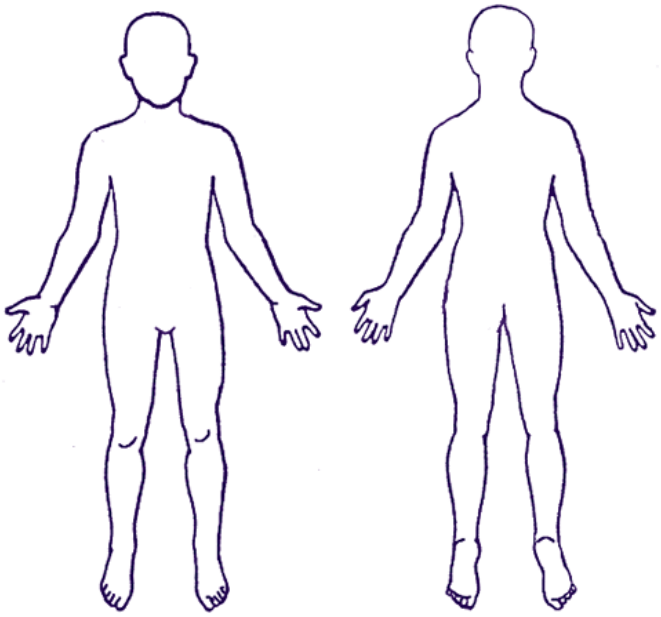
Other health care providers consulted for this condition.

_____

Date of last physical examination_____

Women: Are you or is there a possibility that you may be pregnant?_____ If yes, what is the due date?_____

Please mark the location where you have pain or other symptoms.



Rate the severity of your pain

0 1 2 3 4 5 6 7 8 9 10

Please indicate if you have had (P) or currently have (C) any of the following conditions

Cardiovascular

___Fainting ___Heart Disease ___High/Low Blood Pressure ___Irregular Heartbeat ___Phlebitis ___Poor Circulation ___Swelling of Hands/Feet
___Swelling of Legs ___Other_____

Ears/Nose/Throat

___Dizziness ___Hearing Loss ___Sinus Infection ___Nose Bleed ___Sore Throat ___Jaw Clicks ___Bleeding Gums ___Difficulty Swallowing
___Other_____

Gastrointestinal

___Nausea/Vomiting ___Liver Problems ___Constipation ___Diarrhea ___Ulcers ___Black/Bloody Stools ___ Gallbladder Problems

___Bowel Problems ___Other_____

Musculoskeletal

___Osteoporosis ___Arthritis ___Joint Stiffness ___Muscle Weakness ___Gout ___Broken Bones ___Joints Replaced
___Other_____

Respiratory

___Asthma ___Bronchitis ___Cold/Flu ___Cough/Wheezing ___Emphysema ___Difficulty Breathing ___Pneumonia ___Shortness of Breath
___Other_____

Eyes

___Glaucoma ___Double Vision ___Blurred Vision ___Color Blindness ___Cataracts ___Glasses ___Eye Pain ___Poor Vision

Genitourinary

___Kidney Disease ___ Burning Urination ___ Frequent Urination ___ Blood in Urine ___Kidney Stone ___Lower Side Pain
___Other_____

Neurological

___Stroke ___Seizures ___Severe Headaches ___Numbness ___Head Injury ___Pinched Nerves ___Carpal Tunnel ___Brain Aneurysm
___Other_____

Hematologic/Lymphatic

___Hepatitis ___Blood Clots ___Easy Bleeding ___Easy Bruising ___Cancer ___Fever ___Chills ___Sweats___ Other_____

Endocrine/Constitutional

___Diabetes ___Thyroid Disorder ___Menstrual Problems ___Weight Gain ___Weight Loss ___Difficulty Sleeping ___Other_____

Surgeries:_____

Serious illness or injury:_____Allergies:_____

Medications taken within the last two months (include over the counter and vitamins):_____

Occupational Stresses:_____

Habits: Alcohol (use/week) _____ Tobacco (use/week) _____ Drugs (type, use/week) _____

Are there any other issues concerning your health that you would like the doctor to be aware of?_____

_____

Have you had any other significant traumas? (Auto accidents, falls, etc…):_____

_____

Patient Name (Please Print)_____

Name of Person Completing this form_____

Relationship to the Patient_____

Signature of patient or person completing this form_____ **Date**:_____