Accidents, Injuries and Lifestyle:

Have you ever had any broken bones? [ ] No [ ]Yes (explain)_____
List any falls or accidents (including Car Accidents) (Give Dates):
_____
Have you ever been knocked unconscious or had memory lapses? [ ]No [ ]Yes_____
Have you ever been hospitalized? [ ]No [ ]Yes _____
Have you had any major illnesses? [ ]No [ ]Yes _____
Have you been treated for any conditions in the past 5 years?_____
_____
Have you ever had any spinal taps or spinal injections? ____ No ____Yes _____
When was the last time that you had spinal x-rays? _____
When was the last time that you had Dental x-rays? _____
Types of Exercise: _____
Do you smoke? [ ]No [ ]Yes _____ packs/day
Do you drink alcohol? [ ]No [ ]Yes _____ drinks/day
Do you drink coffee? [ ]No [ ]Yes _____ cups/day
Do you suffer from any other condition other than that for which you are now consulting us?
_____
What is your title/What duties do you perform at your job?:_____
_____
Hobbies:_____
Females: Are you currently pregnant? [ ]No [ ]Yes _____

Prescription Medications (RX):	OTC medication:	Vitamins/Herbs/Supplements:
_____	_____	_____
_____	_____	_____
_____	____	___

Current Chief Complaint: _____

M: Mechanism of Injury: _____
O: Onset _____ P: Palliative: _____
P: Provocative: _____ Q: Quality:_____
R: Radiating/Reffered? _____ S: Severity: ____ / 10
Site: _____ Time (Duration/Frequency): _____
Have you ever had anything like this before? _____
Is your condition getting *better, same,* or *worse*?
Has there been any change in your bodily functions? (urination, defecation, respiration, digestion, vision, sexual, other?) _____
Has your condition affected your daily activities? _____
Have you tried over–the-counter or home remedies?_____
Have you sought other professional care for this condition? Drs. Name _____
Do you have any other symptoms or problems you wish to talk about? _____
Notes: