





Have you ever had treatment with a: (Please list name or location and area treated)

Chiropractor (DC) \_\_\_\_\_

Physical Therapist (PT) \_\_\_\_\_

Osteopath (DO) \_\_\_\_\_

Have you ever had injections for your pain? NO YES Epidural \_\_\_\_\_

Trigger Point \_\_\_\_\_ Other \_\_\_\_\_

Any history of previous surgeries? NO YES (Describe): \_\_\_\_\_

Please check any of the following problems that you may have had:

- |                                 |                                  |                           |
|---------------------------------|----------------------------------|---------------------------|
| Heart disease/Heart attack      | Rheumatic disease                | Dizziness                 |
| High blood pressure             | Arthritis                        | Loss of consciousness     |
| Asthma                          | Swelling in toe or finger joints | Fainting                  |
| Bronchitis / Emphysema          | Neck problems                    | Headaches                 |
| Stomach ulcers                  | Shoulder problems                | Difficulty concentrating  |
| Hepatitis                       | Pain between shoulder blades     | Difficulty with memory    |
| Kidney infections               | Upper extremity problem          | Insomnia                  |
| Kidney stones                   | Leg problem                      | Difficulty falling asleep |
| Prostatic problems              | Painful joint(s)                 | Feeling tired in morning  |
| Change in ability to pass urine | Stiff joint(s)                   | Unexplained weight loss   |
| Difficult bowel movement        | Walking problem                  | Night sweats              |
| Urine incontinence              | Seizure disorder                 | Fever                     |
| Bowel incontinence              | Broken bones                     | Cancer _____              |
| Diabetes                        | Difficulty swallowing            | Other _____               |
| Thyroid disease                 | Tuberculosis                     |                           |

Please list any other medical problems not listed above: \_\_\_\_\_

Do you or have you previously smoked cigarettes? NO YES \_\_\_\_\_ packs per day x \_\_\_\_\_ years

Do you drink alcoholic beverages? NO YES How much per week? \_\_\_\_\_

Do you drink caffeinated beverages? NO YES How much per week? \_\_\_\_\_

What is the approximate amount of water intake you have per day? \_\_\_\_\_

Non-work related activity: \_\_\_\_\_ hours/week

What activities do you participate in: \_\_\_\_\_

Which activities have you been unable to do since your symptoms began that you need or want to get back to?  
\_\_\_\_\_

Marital Status: Single Married Separated Widowed How many children do you have? \_\_\_\_\_

What is your education level: Grade School High School College Post College

Do you have a family history of? Back problems Arthritis Rheumatologic Problems  
Cancer (list relationship and type): \_\_\_\_\_ Other \_\_\_\_\_

***I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.***

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**