

# SUMNER CHIROPRACTIC CLINIC PC

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NAME:

DOB:

List any **Allergies**:

- Animals  Aspirin  Bees  Chocolate  Dairy  Dust  Eggs  Latex  Molds  Penicillin  Ragweed/Pollen  
 Rubber  Seasonal Allergies  Shellfish  Soaps  Wheat  X-Ray Dye  Other:

List any **Surgeries**:

- Back  Brain  Elbow  Foot  Hip  Knee  Neck  Neurological  Shoulder  Wrist  Other:

List **ALL Past Medical History** conditions:

- Ankle Pain  Arm Pain  Arthritis  Asthma  Back Pain  Broken Bones  Cancer  Chest Pain  Depression  
 Diabetes  Dizziness  Elbow Pain  Epilepsy  Eye/Vision Problems  Fainting  Fatigue  Foot Pain  
 Genetic Spinal Condition  Hand Pain  Headaches  Hearing Problems  Hepatitis  High Blood Pressure  
 Hip Pain  HIV  Jaw Pain  Joint Stiffness  Knee Pain  Leg Pain  Menstrual Problems  Mid-Back Pain  
 Minor Heart Problem  Multiple Sclerosis  Neck Pain  Neurological Problems  Pacemaker  Parkinson's  
 Polio  Prostate Problems  Shoulder Pain  Significant Weight Change  Spinal Cord Injury  Sprain/Strain  
 Stroke/Heart Attack  Other:

List Type of **Medications** you are taking:

- Anxiety  Muscle Relaxors  Pain Killers  Insulin  Birth control  Cardio-vascular  Allergy  Seizure  
 Other:

List your **Immediate Family History**:

- Arthritis  Asthma  Back Pain  Cancer  Depression  Diabetes  Epilepsy  Genetic Spinal Condition  
 High Blood Pressure  Heart Problems  Multiple Sclerosis  Neurological Problems  Parkinson's  Polio  
 Prostate Problems  Stroke/Heart Attack

**Please list all family members who had/has any of the problems above:**

Have you been to a chiropractor before?  No  Yes

Have you had treatment outside of this office for your condition?  No  Yes If yes, where:

Have you had any auto or other accidents?  No  Yes Describe:

**Date of last physical exam:**

**Doctor's name:**

**Women Only:**

Are you pregnant?  No  Yes If pregnant in the past, were your pregnancies normal?  No  Yes # of births?

**OB/GYN Physician's Name:**

**Date of last exam:**

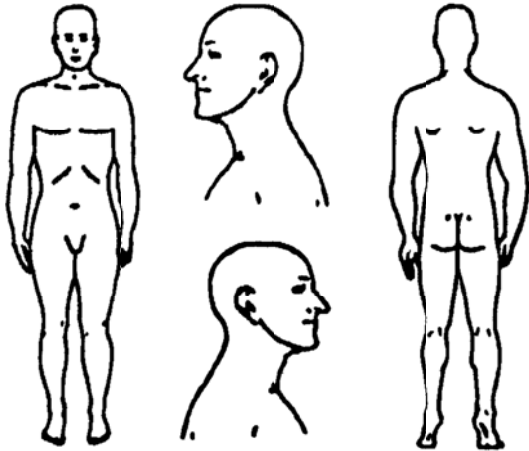
Do you smoke?  No  Yes

Do you drink alcohol?  No  Yes - how many per day?

Do you drink caffeine?  No  Yes - how many per day?

Do you exercise?  No  Yes (what forms and how often):

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity level

What is your major complaint?

Date problem began?

How did this problem begin?

How is your condition changing?  GETTING BETTER  GETTING WORSE  NOT CHANGING

Have you had this condition in the past?  No  Yes

How often do you experience your symptoms?

- Constantly (76-100% of the day)  Frequently (51-75% of the day)
- Occasionally (26-50% of the day)  Intermittently (0-25% of the day)

Describe the nature of your symptoms:  Sharp  Dull  Numb  Burning  Shooting  Tingling  Radiating Pain

Tightness  Stabbing  Throbbing  Other:

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

1  2  3  4  5  6  7  8  9  10

What time of day are you symptoms worse?

How do your symptoms affect your ability to perform daily activities? (0= no effect and 10= no possible activities)

1  2  3  4  5  6  7  8  9  10

What activities aggravate your condition?

Describe your job activities?

Hours worked per week?

Right or Left Handed?  Right  Left

What makes your pain better?

**Signature & Date:**