

### Initial Health Status

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

H. Phone: (\_\_\_\_) \_\_\_\_\_ W. Phone: (\_\_\_\_) \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Social Security #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Have you ever received Chiropractic care prior to today?  Yes  No  
If yes, when, with whom and for what problem?

\_\_\_\_\_

\_\_\_\_\_

Please describe the problem or problems that have prompted you to seek chiropractic care TODAY:

\_\_\_\_\_

\_\_\_\_\_

How and when did the problem(s) begin?

\_\_\_\_\_

\_\_\_\_\_

Please rate the severity of your problem:

(No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

Please indicate type(s) of symptoms or pain:

Dull  Aching  Sharp  Shooting  Burning  Throbbing  Tingling  Numbness  \_\_\_\_\_

How often do symptoms occur and how long do they last? \_\_\_\_\_

What, if anything, aggravates the problem? \_\_\_\_\_

What, if anything, makes the problem better? \_\_\_\_\_

Previous treatments, medications, surgery, or care you've sought for THIS PROBLEM, if any:

\_\_\_\_\_

\_\_\_\_\_

Surgical History:

\_\_\_\_\_

\_\_\_\_\_

Family Health History:  Cancer  Diabetes  High Blood Pressure  Cardiovascular Disease/Stroke  Rheumatoid Arthritis

Social and Occupational History:

Live alone  Live w/ partner or spouse w/ children  Live w/ partner or spouse without children

Single parent living with children  Live with others \_\_\_\_\_

Level of Education:  high school  some college  college graduate  post graduate studies

Work activity description: \_\_\_\_\_ Number of hours/wk: \_\_\_\_\_

Recreational activities & exercise: \_\_\_\_\_

