

PERSONAL INFORMATION		
Name: First:	Last:	Middle Initial:
Date:	Home Phone: ()	Cell: ()
Address:		City:
State:	Zip:	Date of Birth:
EMAIL :		
Referred by:		

HEALTH SYMPTOMS																				
What is your primary symptom?																				
Is this symptom related to <input type="checkbox"/> work injury <input type="checkbox"/> auto accident <input type="checkbox"/> other accident																				
Date symptom began?																				
How does the primary symptom feel? <input type="checkbox"/> Dull/Achy <input type="checkbox"/> Sharp <input type="checkbox"/> Numb <input type="checkbox"/> Tingling <input type="checkbox"/> Burning <input type="checkbox"/> Cold																				
How often do you feel the primary symptom? <input type="checkbox"/> constantly <input type="checkbox"/> daily <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> Yearly																				
Using the scale below, rate how your primary symptom affects your life? (choose one)																				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">1</td> <td style="width: 10%; text-align: center;">2</td> <td style="width: 10%; text-align: center;">3</td> <td style="width: 10%; text-align: center;">4</td> <td style="width: 10%; text-align: center;">5</td> <td style="width: 10%; text-align: center;">6</td> <td style="width: 10%; text-align: center;">7</td> <td style="width: 10%; text-align: center;">8</td> <td style="width: 10%; text-align: center;">9</td> <td style="width: 10%; text-align: center;">10</td> </tr> <tr> <td style="text-align: center;">No pain</td> <td style="text-align: center;">Slight discomfort</td> <td style="text-align: center;">Pain that does not affect my activity</td> <td style="text-align: center;">Pain that affects my activities</td> <td style="text-align: center;">Pain that prevents performing my daily activities</td> <td style="text-align: center;">Pain that limits my work schedule</td> <td style="text-align: center;">Pain that prevents working at all</td> <td style="text-align: center;">Pain that prevents working and all personal activity</td> <td style="text-align: center;">Pain that keeps me bed ridden</td> <td style="text-align: center;">Unbearable Pain</td> </tr> </table>	1	2	3	4	5	6	7	8	9	10	No pain	Slight discomfort	Pain that does not affect my activity	Pain that affects my activities	Pain that prevents performing my daily activities	Pain that limits my work schedule	Pain that prevents working at all	Pain that prevents working and all personal activity	Pain that keeps me bed ridden	Unbearable Pain
1	2	3	4	5	6	7	8	9	10											
No pain	Slight discomfort	Pain that does not affect my activity	Pain that affects my activities	Pain that prevents performing my daily activities	Pain that limits my work schedule	Pain that prevents working at all	Pain that prevents working and all personal activity	Pain that keeps me bed ridden	Unbearable Pain											

What do you believe is causing your primary symptom?

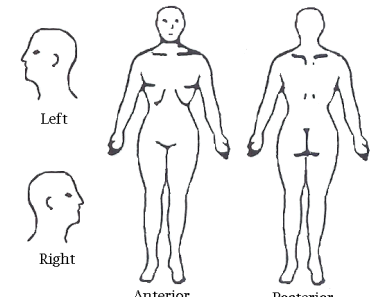
Have you had any spinal X-rays, MRI, CT scan for your area(s) of complaint?

Yes No

Date(s) taken _____

Areas taken _____

Mark an X where you have symptoms:



Left Anterior Posterior

CONDITIONS		
Mark all of the following that apply to you:		
<table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Alcohol/ Drug Dependence <input type="checkbox"/> Recent Fever <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer/Tumor <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV positive <input type="checkbox"/> Dizziness/Fainting </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Numbness in Groin/Buttocks <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) <input type="checkbox"/> Taking Birth Control Pills <input type="checkbox"/> Currently Pregnant <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss <input type="checkbox"/> Pain at Night <input type="checkbox"/> Visual disturbances <input type="checkbox"/> Pain Unrelieved by Position or Rest <input type="checkbox"/> Other Health Problems: _____ </td> </tr> </table>	<input type="checkbox"/> Alcohol/ Drug Dependence <input type="checkbox"/> Recent Fever <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer/Tumor <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV positive <input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Numbness in Groin/Buttocks <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) <input type="checkbox"/> Taking Birth Control Pills <input type="checkbox"/> Currently Pregnant <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss <input type="checkbox"/> Pain at Night <input type="checkbox"/> Visual disturbances <input type="checkbox"/> Pain Unrelieved by Position or Rest <input type="checkbox"/> Other Health Problems: _____
<input type="checkbox"/> Alcohol/ Drug Dependence <input type="checkbox"/> Recent Fever <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer/Tumor <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV positive <input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Numbness in Groin/Buttocks <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) <input type="checkbox"/> Taking Birth Control Pills <input type="checkbox"/> Currently Pregnant <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss <input type="checkbox"/> Pain at Night <input type="checkbox"/> Visual disturbances <input type="checkbox"/> Pain Unrelieved by Position or Rest <input type="checkbox"/> Other Health Problems: _____	

HEALTH QUESTIONS

What services interest you? (mark all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Spinal and Body Alignment
<input type="checkbox"/> Massage Therapy
<input type="checkbox"/> Range of Motion or Flexibility Therapy
<input type="checkbox"/> Nutritional and Supplement Counseling
<input type="checkbox"/> Craniosacral Therapy
<input type="checkbox"/> Behavior Modification (focus, attention, communication) | <input type="checkbox"/> Pediatric Care
<input type="checkbox"/> Pregnancy Care/ Webster Technique
<input type="checkbox"/> Autism Recovery
<input type="checkbox"/> Breast Thermography
<input type="checkbox"/> Therapeutic Listening |
|--|---|

LIFESTYLES & HABITS

- | | | | | |
|---|-----------------------------------|--------------------------------|---------------------------------|--------------------------------|
| How many hours of television do you watch a day? | <input type="checkbox"/> <1 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-5 | <input type="checkbox"/> >5 |
| Do you usually snack while watching television? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| How many hours do you use the computer a day? | <input type="checkbox"/> <1 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-5 | <input type="checkbox"/> >5 |
| How many hours do you ride/drive a vehicle a day? | <input type="checkbox"/> <1 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-5 | <input type="checkbox"/> >5 |
| How many days per week do you exercise? | <input type="checkbox"/> <1 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-5 | <input type="checkbox"/> >5 |
| How long do you exercise? | <input type="checkbox"/> <30 min. | <input type="checkbox"/> <1 hr | <input type="checkbox"/> 1 hour | <input type="checkbox"/> >1 hr |

What are you exercise activities?

- | | | | | |
|----------------------------------|--|--|---|---|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Stretching/Flex | <input type="checkbox"/> Running/Tread | <input type="checkbox"/> Swimming | <input type="checkbox"/> Weight lifting |
| <input type="checkbox"/> Yoga | <input type="checkbox"/> Pilates | <input type="checkbox"/> Group Class | <input type="checkbox"/> Resistance bands | <input type="checkbox"/> Other |

NUTRITIONAL SUPPLEMENTS

List any nutritional supplements you are currently taking:

Supplement	Reason	Supplement	Reason
1 _____		4 _____	
2 _____		5 _____	
3 _____		6 _____	

- | | | | | | |
|---|--------------------------------|---------------------------------|----------------------------------|---------------------------------|--------------------------------|
| How often do you use tobacco? | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Yearly | <input type="checkbox"/> Never |
| How many serving of alcohol do you drink each week? | <input type="checkbox"/> <0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-5 | <input type="checkbox"/> >5 | |
| How many serving of Coffee do you drink each week? | <input type="checkbox"/> <0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-5 | <input type="checkbox"/> >5 | |
| How many serving of Soda do you drink each week? | <input type="checkbox"/> <0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-5 | <input type="checkbox"/> >5 | |
| How many serving of Tea do you drink each week? | <input type="checkbox"/> <0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-5 | <input type="checkbox"/> >5 | |
| How many serving of Water do you drink each week? | <input type="checkbox"/> <0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-5 | <input type="checkbox"/> >5 | |

FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family.

- | | | | | |
|-----------------------|---------------------------------|---------------------------------|---------------------------------|----------------------------------|
| Diabetes | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother |
| Heart problems/Stroke | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother |
| Cancer | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother |
| Arthritis | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother |
| High Blood Pressure | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sister | <input type="checkbox"/> Brother |

SURGERIES/INJURIES

List any auto accidents, job injuries, sports injuries or other injuries you've experienced:

Surgery/Injury	Date	Surgery/Injury	Date
1 _____	_____	2 _____	_____
3 _____	_____	4 _____	_____

MEDICATIONS

List any medications you are currently taking:

Medication	Reason	Medication	Reason
1 _____	_____	3 _____	_____
2 _____	_____	4 _____	_____

I understand and agree to the following:

- I am requesting and consenting to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or patient named for which I am legally responsible) which are recommended by Donald G. Gerken, DC, DACCP, CST, Diane Gerken, DC, Adrienne L. Young, DC and/or other licensed doctors of chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as backup for my treating doctor of chiropractic
- It is my responsibility to complete the clinic's forms accurately
- It is my responsibility to notify the doctor if any of my information has changed or requires updating
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request

Patient Name

Patient Signature (Parent/Guardian if under 18 years)

Date