REVITALIZE
CHIROPRACTIC

First Name _____ Last Name _____ Date _____
Address _____
Cell Phone _____
Email _____
Date of Birth ____/_____/_____
Sex (circle one) M or F
Marital Status (circle one) Single Married Divorced
Significant Other Name _____
Number of children _____
Employer and city _____
Job Title _____
Whom may we thank for referring you to us? _____
Emergency Contact _____
Relationship and Phone Number _____
Family Physician _____
City they are located in _____
Have you received chiropractic care before? If so, for how long and what was the result?
_____
_____

What was the primary reason for seeking care at our office?
_____
_____

Rate your primary pain or discomfort on a scale of 1-10 (circle one)
1 2 3 4 5 6 7 8 9 10

Progression of primary complaint (circle one)
Worsening Staying the same

Secondary or other areas of complaint (please provide a description, if applicable)
_____
_____

Progression of secondary complaint (circle one)
Worsening Staying the same

Were you injured at work or in a car accident? (If so, please describe the incident and add when the incident occurred)

_____

_____

How long have you had your primary complaint?

_____

_____

What aggravates your primary complaint? Circle all that apply

Nothing	Exercise	Sleeping
Sitting	Laying down	Stress
Standing	Bending	Work
Walking	Computer work	Chores at house
Running	Driving	Twisting
Other _____		

What relieves your primary complaint? Circle all that apply

Nothing	Strength Training	Prior Chiropractic Treatment
Heat	Walking	Electric therapy
Ice	Rest	Massage
Stretching	Medication	Laying down
Other _____		

<u>Health History Questionnaire (Please circle all that may apply)</u>

General Symptoms (Circle all that apply)

Loss of consciousness	Nights Sweats	Loss of sleep
History of headaches	Night pain	Allergies
History of migraines	Generalized pain	Loss of bowel or bladder control
Fever	Nervousness	Excess sweating

Neurological Symptoms (Circle all that apply)

Dizziness	Problem speaking	Blurred Vision
Fainting	Nausea	Numbness or tingling
Radiating pain		

Eyes / Ears / Nose / Throat (Circle all that apply)

Failing vision	Eye pain	Ringing / Buzzing in ears
Vision problems	Hearing loss	

Respiratory Symptoms (Circle all that apply)

Asthma	Chronic Cough	Difficulty breathing
Shortness of breath	Bronchitis	Emphysema

Cardiovascular Symptoms (Circle all that apply)

Bleeding disorder	Hardening of arteries	Previous heart attacks
High blood pressure	Swelling of ankles	Phlebitis / Varicose veins
Low blood pressure	Poor circulation	Pacemaker
Previous stroke	Angina	
Cerebral Vascular Aneurysm	Chronic Congestive Heart Failure Treatment	

Gastrointestinal Symptoms (Circle all that apply)

Jaundice	Irregular or absent bowel movements	Ulcer
Diabetes	Indigestion	GERD

Genitourinary Symptoms (female only) (Circle all that apply)

Hot flashes	Irregular or absent cycle	Cramping / back pain

Are you currently pregnant? (Circle which applies to you)

Yes

When is your due date? _____

No

Have you ever had surgery? (Circle which applies to you)

Yes

Please provide location and year _____

No

Have you ever had any fractures? (Circle which applies to you)

Yes

Please provide area and year? _____

No

Have you had any X-rays, Ct scans, ultrasounds or MRIs in the past 5 years?(Circle which applies to you)

Yes

List clinic/hospital and the area examined? _____

No

Have you ever been diagnosed with cancer?

Yes

Please provide details _____

No

Please list your medications, herbs, supplements

_____

_____

How would you best describe your overall activity level? (Circle which applies to you)

Very active Somewhat active Rarely active

How would you best describe your stress level? (Circle which applies to you)

High Medium Low

Family Medical History (Please check if any immediate family members suffer from the following) (Circle which applies to you)

Headaches or migraines	Inflammatory bowel disease	Stroke
High or low blood pressure	Circulatory Problems	Asthma
Diabetes Cancer	Respiratory Disorders	Epilepsy
Heart Disease	Neurological Disorders	Multiple Sclerosis
Fainting or Dizziness	Kidney Disease	Fibromyalgia
Osteoporosis	Osteoarthritis	

Please add any additional information that you feel is pertinent

_____

_____

_____

_____

_____