Date _____ Case No. _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (_____)-_____-_____ Work Phone (_____)-_____-_____

Cell Phone (_____)-_____-_____ Email Address _____

Social Security Number _____ Date of Birth _____

Sex _____ Marital Status _____ Occupation _____

How did you find us? _____

Have you liked "Roscoe Chiropractic Centre" on Facebook? _____ Yes ____ No

If no, please like us so you can be kept up to date on office events, any changes to our hours, special contests for prizes, etc!

What are your hobbies/interests? _____

Do you have any non-pain related health complaints (such as digestive issues, breathing problems, allergies, heart conditions, bowel and bladder problems, etc.)

_____

_____

_____

Are you taking any medications for these complaints? _____Yes _____ No

If yes, please list them: _____

_____

Is there anything that you would like to do that your health problem(s) is preventing you from doing? _____

Is there anyone in your family that has this or a similar condition? _____ Yes _____ No

How old do you feel? _____

Do you have and children? _____ Yes _____ No

How many and what are their ages? _____

_____

If you could be any animal, what kind of animal would you be? _____

Why? _____

Date _____ Case No. _____

Present Complaints

_____

_____

_____

**O ------ Onset:**

How did it happen? _____

_____

When did it happen? _____

Have you experienced this before?_____

**P ------ Palliative/Provoking:**

What makes it better? _____

What makes it worse? _____

**Q ------ Quality of Pain and/or symptoms:**

Describe the pain/symptoms (throbbing, aching, burning, etc.)? _____

**R ------ Radiation/Referral:**

If there is pain, does it travel from its site to anywhere else? (if so, where?) _____

_____

**S ------ Site/Setting/Severity:**

If you have pain, on a scale of 1-10, 1 being the best you've ever felt, where would your pain fall? 1 2 3 4 5 6 7 8 9 10

If you are experiencing pain, describe where it is located: _____

_____

**T ------ Timing:**

Is this a constant problem? _____

What time of day does it occur? _____

Date _____ Case No. _____

**Past History**

Have you seen any other doctor (Chiropractor, medical, dentist, etc.)? in the past 6 months? _____

If yes, please describe _____

_____

Are you currently taking any medications? If yes, what? _____

_____

What surgeries have you had? (include dates) _____

_____

What accidents/traumas/falls/injuries have you had? (include dates)

_____

_____

Have you ever seen a Chiropractor before? _____

If so, when and who? _____

How long were you under care? _____

Reason for stopping? _____

_____

Results of care: _____

Doctor's Notes:

_____

_____

_____

_____

_____

_____

_____

Date of Onset: _____

Date _____ Case No. _____

**Please check all conditions you have or have had.**

**General**
□ Allergy
□ Chills
□ Convulsions/seizures
□ Dizziness
□ Fainting
□ Fever
□ Headache
□ Loss of sleep
□ Loss of weight
□ Migraines
□ Nervousness/depression
□ Numbness
□ Sweats
□ Tremors
□ Other _____

**Eyes/Ears/Nose/Throat**
□ Colds
□ Crossed-eyes
□ Deafness
□ Earache
□ Ear Noise
□ Enlarged glands
□ Enlarged Thyroid
□ Eye pain
□ Failing vision
□ Glasses
□ Farsightedness
□ Nearsightedness
□ Gum trouble
□ Hay Fever
□ Hoarseness
□ Stuffy Nose
□ Nose Bleeds
□ Sinus Infection
□ Sore throat
□ Tonsillitis
□ Other _____

**Respiratory**
□ Chest Pain
□ Chronic Cough
□ Coughing up blood
□ Difficulty breathing
□ Wheezing
□ Other _____

**Cardiovascular**
□ Hardening of arteries
□ High blood pressure
□ Low blood pressure
□ Night sweats
□ Pain over heart
□ Poor circulation
□ Rapid heartbeat
□ Slow heartbeat
□ Swelling of ankles
□ Other _____

**Gastrointestinal**
□ Abdominal pain
□ Belching or gas
□ Colitis
□ Colon trouble
□ Constipation
□ Diarrhea
□ Difficult digestion
□ Bloated abdomen
□ Excessive hunger
□ Gallbladder trouble
□ Hemorrhoids
□ Jaundice
□ Liver trouble
□ Nausea
□ Pain over stomach
□ Poor appetite
□ Vomiting
□ Other _____

**Genitourinary**
□ Bed-Wetting
□ Blood in urine
□ Frequent Urination
□ Lack of bladder control
□ Kidney infection
□ Painful urination
□ Prostate troubles
□ Venereal diseases
□ Other _____

**Skin**
□ Boils
□ Bruise easily
□ Dryness
□ Hives or allergy
□ Itching
□ Shingles
□ Skin Eruptions
□ Varicose veins
□ Other _____

**Muscle/Joint**
□ Arthritis
□ Bursitis
□ Food trouble
□ Hernia
□ Pain between shoulders
□ Poor Posture
□ Sciatica
□ Spinal Curvature
□ Swollen joints
□ Other _____

**Women Only**
□ Cancer
□ Cramps or backache
□ Excess menstrual flow
□ Fertility problems
□ Hot flashes
□ Irregular cycle
□ Lumps in breast
□ Menopause
□ Other _____
Are you pregnant? □ y □ n
If yes, how long? ____ months
Number of children _____

**Habits**
□ Alcohol
□ Artificial sweeteners
□ Coffee
□ Tobacco
□ Drugs
□ Exercise
□ Salty Foods
□ Soft drinks
□ Sugar
□Water
Appetite □ Good □ Poor
Sleep □ Good □ Poor

Date _____ Case No. _____

Check any of the following conditions that you currently have, or have had:

□ Alcoholism
□ Arteriosclerosis
□ Chicken Pox
□ Diphtheria
□ Epilepsy
□ Herpes
□ Miscarriage
□ Pacemaker
□ Polio
□ Scarlet Fever
□ Typhoid Fever
□ Whooping cough
□ Anemia
□ Asthma
□ Cold Sores
□ Eczema
□ Gout
□ Influenza
□ Multiple sclerosis
□ Parkinson's
□ Polio
□ Stroke
□ Ulcers
□ Appendicitis
□ Cancer
□ Diabetes
□ Emphysema
□ Heart disease
□ Measles
□ Mumps
□ Pneumonia
□ Rheumatic Fever
□ Tuberculosis
□ Venereal disease

**Vaccinations**
□ Chicken pox
□ DPT
□ Flu
□ MMRV
□ Polio
□ Smallpox
□ Others _____

**Family History**

Have any of the following occurred in your family?
□ Diabetes
□ Heart Disease
□ Hypertension
□ Tuberculosis
□ Cancer
□ Arthritis
□ Stroke
□ Tuberculosis
□ Mental History

If yes, please answer the following questions:
Who in your family has had which condition?

Are they alive? If not, did they die from this condition?

Are your parents and siblings still living? If not, what did they die from, and how old were they?