**Jennings County Chiropractic**

Name_____Date_____
Address_____State____Zip_____
Home phone_____Cell Phone_____Work Phone_____
Email address_____ Sex: M F Age _____
DOB _____SS# _____ Marital Status _____
Occupation _____ Employer _____
Work Address _____
If a minor, Parents/Guardians Name _____
Parents' Address_____
Parents' phone numbers _____
How did you hear about our office? _____
What's the reason for today's visit? _____
If you have a Main Complaint: What is your major symptom? _____
What does this prevent you from doing/enjoying? _____
What is your treatment goal? _____
If this is a reoccurrence, when was the first time you noticed the problem? _____
How did it originally occur? _____
Has it become worse recently? _____ Is it becoming gradually worse? _____
If yes, when and how? _____
How frequent is the condition? Constant _____ Daily _____ Intermittent _____ Nights only _____
How long does it last? All day_____ A few hours_____ Only minutes _____
Is this pain: Sharp _____ Dull _____ Numbness _____Tingling _____ Aching _____Burning _____
Stabbing _____ Other _____
Is there anything to relieve the pain? _____ If yes, describe _____
If no, what have you tried? _____
What makes the problem worse? Standing _____ Sitting _____ Lying _____ Bending _____
Lifting _____ Twisting _____ Other _____
Have you broken any bones? _____ Please list with dates _____
List any major accidents you've had _____

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To your knowledge, have you had any diseases, major illnesses, or injuries not indicated here _____

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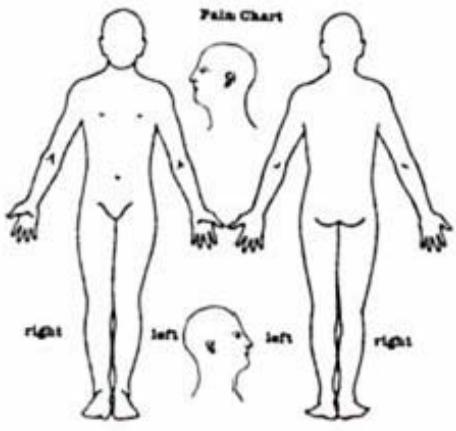
Are there any other symptoms that may be related to your main complaint? _____
If yes, please describe _____
Are there other health problems? _____ If yes, please describe _____

WOMEN ONLY: Are you or might you be pregnant? _____
Please place an X on the line below to indicate level of main complaint.
No Pain_____Unbearable pain

On the illustration to the right,
Mark area(s) of pain, inflexibility
Or discomfort



**History** – Past chiropractic care/ doctor's name_____
Family physician _____ Medications_____
Surgery/ dates _____
Illnesses/ Abnormalities _____
Previous injuries/ dates _____
Please place an F or M, both or leave blank to indicate your family history with: Cancer _____ type_____
Cardiovascular disease _____ Osteoporosis _____ Alcoholism _____ Mental illness/depression _____
Obesity _____Alzheimer's _____ Diabetes _____ Arthritis _____ Allergies _____

**Lifestyle and Diet** – Rate your current level of stress 1-10 with 1 being low_____ What are the major causes?
Work _____ Family _____ Relationships _____ Finances _____ Health _____ Other _____
I eat: Sweets _____ Sodas _____ Dairy _____ Fruits _____ Vegetables _____ Legumes _____ Gluten ____
My favorite 4 foods are: _____
I diet frequently ____ Skip meals ____ Eat out (circle or fill in) 1 2 3 4 5 6 7 8 9 more ___ times per week.
I eat: morning _____ afternoon _____ evening _____ night _____ snack throughout _____
Do you restrict or avoid: Fiber _____ Salt _____ Sugar _____ Fat _____ Dairy _____ Animal protein _____
Do you exercise weekly? _____ If yes, how much per week?_____
Do you use tobacco? _____If yes, how much daily? _____
If no, did you ever? _____ If yes, for how long? _____
Are you exposed to second hand smoke? _____ If yes, how much daily? _____
Do you drink a caffeinated drink daily? _____ If yes, how much daily? _____
Do you eat sweets daily? _____ If yes, how much daily? _____
Do you drink alcohol? _____ If yes, how much daily? _____

**Do you have difficulty with any of the following?**

- o Headaches
- o Shooting head pain
- o Sinus trouble
- o Hay fever
- o Loss of smell
- o Tightness in throat
- o Inflammation of throat
- o Thyroid trouble
- o Twitching of face
- o Loss of memory
- o Fatigue
- o Depression
- o Head heaviness
- o Weight gain
- o Fainting
- o Loss of balance
- o Ringing in ears
- o Dizziness
- o Light sensitivity
- o Neck muscle spasms
- o Grating in neck
- o Shoulder stiffness
- o Tingling in hands
- o Cold hands
- o Chest pain
- o Shortness of breath
- o Heart palpitation
- o Weight loss
- o High blood pressure
- o Low blood pressure
- o Anemia
- o Rheumatic fever
- o Stomach trouble
- o Ulcers
- o Nervousness
- o Tense
- o Irritability
- o Cold sweats
- o Liver trouble
- o Gall bladder trouble
- o Indigestion
- o Constipation
- o Bladder trouble
- o Menstrual pain
- o Menstrual irregularity
- o Diabetes
- o Cancer
- o Trouble sleeping
- o Painful joints
- o Swollen joints
- o Arthritis
- o Slipped disc
- o Pinched nerve
- o Tingling in legs
- o Swollen ankles
- o Swollen feet
- o Cold feet
- o Leg pain
- o Foot pain
- o Kidney trouble