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Valley CHIROPRACTIC CLINIC, INC

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Name:_____ **Case:**_____ **Date:**_____
(Please Print) *(Filled out by Staff)*

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Sex: ❑ *Male* ❑ *Female* Date of Birth (Month/Day/Year): _____ / _____ / _____ Age: _____

Describe your current complaints: _____

_____

_____

_____

List any other doctors seen for this condition along with diagnosis and treatment given: _____

_____

_____

List any pertinent previous history: _____

_____

_____

Does this condition interfere with your: ❑ Work? ❑ Sleep? ❑ Leisure Activities?

What seems to aggravate this condition? _____

_____

Have you received chiropractic treatment previously? ❑ *Yes* ❑ *No*

Has a physician treated you for any other health condition in the last year? ❑ *Yes* ❑ *No*. If "Yes," explain:

_____

_____

Are you currently under medication? ❑ *Yes* ❑ *No* If "Yes," please list _____

_____

List the approximate dates of any surgery or unusual diseases you have had: _____

_____

_____

Was this injury work related? ❑ *Yes* ❑ *No* If "Yes," whom did you report it to? _____

Was this injury auto – or other – accident related? ❑ *Yes* ❑ *No* If "Yes," date of accident: _____

(Please continue to fill out form on reverse side)

Health History

Please mark items below with a "1" if currently have, or a "2" if previously had…

Musculoskeletal System

___ Low back problem
___ Pain between shoulders
___ Neck problems
___ Arm problems
___ Leg problems
___ Swollen joints
___ Painful joints
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Muscle spasms
___ Walking problems
___ Ruptures
___ Broken bones

Genitourinary System

___ Bladder trouble
___ Excessive urine
___ Scanty urination
___ Painful urination
___ Discolored urine

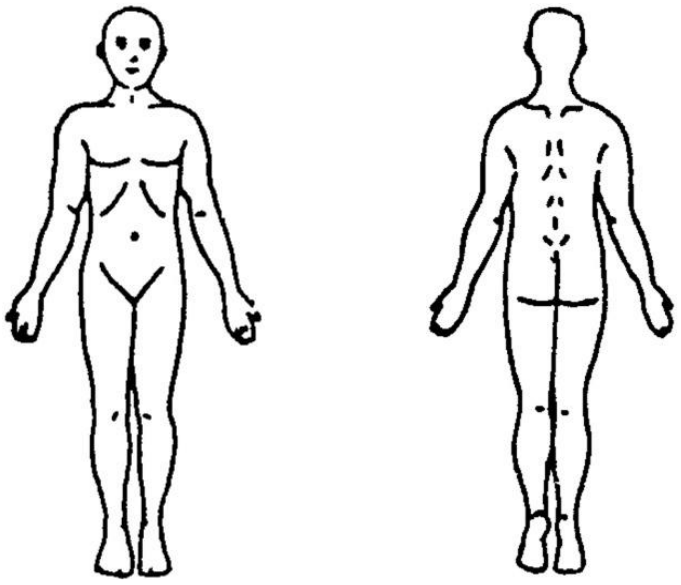
Female (Any Abnormal)

___ Vaginal discharge
___ Vaginal bleeding
___ Vaginal pain
___ Breast pain
___ Lumps on breast

Are you pregnant?

❑ *Yes* ❑ *No*

Please mark your areas of pain on the figures below.
Use a 1 to 10 scale, with 1 being little pain and 10 being the worst possible pain.



Gastrointestinal System

___ Poor appetite
___ Excessive hunger
___ Difficult chewing
___ Difficult swallowing
___ Excessive thirst
___ Nausea
___ Vomiting food
___ Vomiting blood
___ Abnormal pain
___ Diarrhea
___ Constipation
___ Black stool
___ Bloody stool
___ Hemorrhoids
___ Liver trouble
___ Gall bladder trouble
___ Weight trouble

Nervous System

___ Numbness
___ Loss of feeling
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

Cardiovascular and Respiratory

___ Chest pain
___ Pain over heart
___ Difficulty breathing
___ Persistent cough
___ Smoker
- Packs per day _____
___ Rapid heartbeat
___ Blood pressure problems
___ Heart problems
___ Lung problems
___ Varicose veins

Eye, Ear, Nose, and Throat

___ Eye strain
___ Eye inflammation
___ Vision problems
___ Ear pain
___ Ear noises
___ Hearing loss
___ Ear discharge
___ Nose pain
___ Nose bleeding
___ Nose discharge
___ Difficult breathing thru nose
___ Sore gums
___ Dental problems
___ Sore mouth
___ Sore throat
___ Hoarseness
___ Difficult speech

In the event x-rays are needed, I understand that the x-ray fees are for the interpretation and reading by the doctor and that said x-rays are a part of the permanent records of this clinic. I understand that they may be, with a written release, transferred to another doctor in order that he/she may review them for a thirty-day period. At the end of thirty days they must be returned to Valley Chiropractic Clinic, Inc. The x-rays may be copied for my personal records for a nominal per-disk fee of $15.00.

_____ _____
Patient Signature Date Signed