

Last Name: _____ First: _____ MI: _____

Address: _____

SSN: _____ Home Phone: _____ Cell: _____ Birthday: _____

Employer: _____ Address: _____ Work Phone: _____

Spouse's Name: _____ Email: _____

Who's responsible for this bill?: Myself Spouse Parent Insurance Medicare Auto Work Comp Other

Who were you referred by: _____

What is your major complaint?: _____

Rate your pain on a scale of 1 to 10: (none) 1 2 3 4 5 6 7 8 9 10 (severe). Date of injury/ onset: _____

Was the onset of pain: Sudden Gradual? Have you had this pain before? Y N Is the pain: Worse Improving Unchanged?

Describe your pain/ symptoms: Dull Achy Stiff Sharp Shooting Numb Tingling Burning Weakness Cramping

Constant Coming & Going Other: _____

What makes your pain/ symptoms better? _____

What makes your pain/ symptoms worse? _____

Does the pain restrict your daily activities? Y N If yes, describe: _____

Was this an auto or work- related accident? Y N If yes, describe: _____

Please list any medications you are now taking (include over the counter medicine): None _____

HAVE YOU HAD ANY OF THE FOLLOWING IN THE LAST 10 YEARS:

- | | | |
|---|---|--|
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Shoulder Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Weight Trouble |
| <input type="checkbox"/> Pain btw./ in Shoulders | <input type="checkbox"/> Lung/ Breathing Problems | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arm/ Hand Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Leg/ Foot Pain | <input type="checkbox"/> Heart Disease/ Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Loss of Equilibrium/ Balance | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Loss of Feeling | <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Stiff or Painful Joints | <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent Colds/ Illnesses |
| <input type="checkbox"/> Muscle Cramps/ Spasms | <input type="checkbox"/> Female Issues | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Nausea | <input type="checkbox"/> Dizziness/ Vertigo |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Tiredness/ Fatigue | <input type="checkbox"/> Tinnitus (ringing in ears) | <input type="checkbox"/> Poor Digestion |
| <input type="checkbox"/> Numbness/ Tingling | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Gastrointestinal Problems |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Jaw/ TMJ Pain | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Excessive Thirst |

Are You Pregnant? Yes No Date of Last Menstrual Cycle _____

Please list and describe any of the following:

- Car Accidents: _____

- Falls/ Injuries (including sports): _____

- Other Traumas: _____

- Major Illnesses/Diseases: _____

Names of Doctors (MD): _____

Have you ever had surgery or been hospitalized? Yes No If yes, describe _____

Have you ever had Chiropractic care before? Yes No Name of Chiropractor: _____

Describe significant family history: _____

Do you grant GRC permission to contact your doctors regarding your care here? Yes No

Patient's Signature: _____ Date: _____