Welcome to our office! Please take a few minutes to fill out your information as accurately as you can, so we can fully understand your condition. Please feel free to ask our office staff if you need assistance. Thank you.

Legal Name: ____________________________________________ Date: ___________________
Name you would like us to use: ______________________ Phone #: ______________________
Gender: Male / Female Age: ________ Date of Birth: ________________________

## Current Condition

Do you have a complaint? Describe: __________________________________________________
When did this start? __________________ How (if known)?_________________________________
Is this a result of: ___work injury ___auto accident ___personal injury ___other
Have you ever had similar symptoms? Yes___ No___ When? ______________________________
Does anything make your symptoms better? _____________________________________________
Does anything make your symptoms worse? _____________________________________________

Choose the best descriptions for your problem: *(Check mark all that apply)*
__steady/constant __comes & goes __throbbing __aching __pulling/tight band
__sharp/stabbing __shooting __electrical __boring __fatigue/weak
__vise-like __heavy pressure __itching __crawling __colic
__numbness __tingling __stiffness

Please rate the intensity of your symptoms (circle)
At time of onset: *No pain/problems* 0 1 2 3 4 5 6 7 8 9 10 *Worst pain possible*
Today: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the day are you in pain? 0 10 20 30 40 50 60 70 80 90 100%
What percentage do you rest due to pain? 0 10 20 30 40 50 60 70 80 90 100%

How has the problem affected your personality?
___normal, no effect, alert, cheerful
___slightly upset, irritable, complaining
___moderately upset, unhappy, anxious
___severely upset, depressed, bitter
___totally incapacitated, avoid everyone

Has your condition affected your employment, home life, social life or physical activities?
Explain.________________________________
_______________________________________
_______________________________________

What other doctors have you seen for this condition?
_____________________________________
Date of that visit? _____________ Their diagnosis? _____________________________________
Their treatment? _______________________________________________________________
Results of treatment: Good Fair Poor
Have you tried any self treatment? If so, please explain. __________________________________

RIVERSIDE CHIROPRACTIC CENTER
A Healthy Touch from Pediatrics to Geriatrics



Date:______________________________
Name:_____________________________

## Past Medical History

Check those conditions which apply. When was it first noticed or diagnosed?

| Condition | Year | Condition | Year |
|---|---|---|---|
| anemia | _____ | allergies | _____ |
| asthma | _____ | Alzheimer's | _____ |
| bladder infections | _____ | bleed/bruise easily | _____ |
| blood clots/DVT | _____ | bronchitis | _____ |
| cancer | _____ | carpal tunnel syndrome | _____ |
| cerebral palsy | _____ | chicken pox | _____ |
| cirrhosis of the liver | _____ | colitis/IBS | _____ |
| constipation | _____ | depression | _____ |
| disc herniation | ____ | diabetes | _____ |
| emphysema | _____ | endometriosis | _____ |
| glaucoma | _____ | gout | _____ |
| heart trouble | _____ | hemorrhoids | _____ |
| high blood pressure | _____ | impotence | _____ |
| incontinence(bowel/bladder) | _____ | gall bladder/stones | _____ |
| kidney problems | _____ | lung disease | _____ |
| nervous breakdown | _____ | measles | _____ |
| mumps | _____ | osteoarthritis | _____ |
| Parkinson's | _____ | rheumatoid arthritis | _____ |
| scoliosis | _____ | shingles | _____ |
| seizure disorder | _____ | skin disorder | _____ |
| sinusitis | _____ | thyroid problems | _____ |
| varicose veins | _____ | STD (sexually transmitted) | _____ |

## Surgical History

| | | | |
|---|---|---|---|
| disc repair | _____ | spinal fusion | _____ |
| hip replacement | _____ | knee replacement | _____ |
| tonsillectomy | _____ | appendectomy | _____ |
| gall bladder removal | _____ | prostate surgery | _____ |
| stomach surgery | _____ | heart surgery | _____ |
| breast surgery | _____ | ovary removal | _____ |
| hysterectomy | _____ | cesarean section | _____ |
| hernia repair | _____ | varicose vein surgery | _____ |
| carpal tunnel surgery | _____ | thyroid surgery | _____ |

List any other medical problems, illness, injuries or fractures you have had:

_____________________________________________________________________________

Do you wear any orthodics, heel lifts, braces or supports, etc.?

Explain_______________________________________________________________________

When was your last exam? Please give approximate date and the doctor.

Physical exam _________________________ Dental exam______________________________

Eye exam___________________________ Pap/prostate___________________________

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Date:___________________________
Name:__________________________

Do you have episodes of dizziness, fainting, disorientation or slurred speech? ___yes ___no
Do you have a family history of (*please check all that apply*):
___stroke ___diabetes ___heart disease ___genetic disease ___cancer ________other

## Social History

How much alcohol do you consume per week? None 2-4 4-8 8-12 12+ drinks
Do you smoke cigarettes? ___no ___yes, _____packs/day for _____years
Have you undergone any recent ___weight gain ___weight loss _________pounds
Are you on any special diet? Explain.___________________________________________
What type of exercise do you do regularly?_______________________________________

## Work Patterns

Occupation: ____________________________________________ Hours/week? ____________
How many hours of the day do you spend:
sitting_______ standing______ overhead arm work_______
bent forward________ looking down________ at a computer________

What is the average weight of the objects you lift each day? ______________________pounds
How many times per day do you lift these objects? ______________________________times/day

**Please indicate your normal use of the items below**

| ITEM | Never | X/month | X/week | X/day |
|---|---|---|---|---|
| Sweets | | | | |
| Processed food | | | | |
| Regular soda | | | | |
| Diet soda | | | | |
| Coffee | | | | |
| Dairy | | | | |
| Fresh Vegetable | | | | |
| Tobacco | | | | |
| Illicit Drugs | | | | |

**Please list all the medications you are currently taking**

| Medication | Dosage | Reason for taking | How long taken | Dr. prescribed by |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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