

Discover Chiropractic

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Patient Name _____ Today's Date _____
 Birthdate _____ Age _____ Sex: M / F Status: M / S / D / W # of Children _____
 Address _____ City _____ Zip _____
 Cell Phone # _____ Home Phone # _____ Email _____
 Occupation: _____ Employer: _____ Work Phone # _____
 Emergency Contact Name & Phone # _____
 Primary Care Physician _____ PCP Phone # _____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Headache Neck Pain Mid-Back Pain Low Back Pain Other _____
 Is This? Work Related Auto Related N/A
 Date Problem Began _____ How Problem Began _____

Did the problem begin: Gradually? Suddenly?

On a 1-10 pain scale, where "0" is no pain and "10" is the worst possible pain, how would you rate your problem?

None 0 1 2 3 4 5 6 7 8 9 10 Unbearable
 Now _____ At its worse? _____ On average? _____ Prior to DOI? _____

How often are your symptoms present?

Occasional 0-25% 26-50% 51-75% 76-100% Constant

In the past week, how much has your pain interfered with your daily activities (i.e. work, social, household)

None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

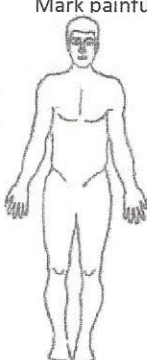
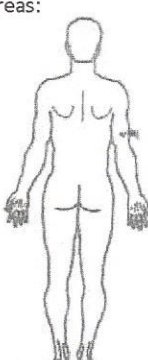
In general how you say your overall health is right now?

Excellent Very Good Good Fair Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? NO Yes

Date(s) taken: _____ What areas were taken? _____

Please check all of the following that apply to you: (Use the back side of this sheet if necessary)

<input type="checkbox"/> Alcohol/Drug Dependence <input type="checkbox"/> Recent Fever <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke (Date) _____ <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) <input type="checkbox"/> Taking Birth Control Pills <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Numbness in Groin/Buttocks <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Other Health Problems (Explain) _____ <input type="checkbox"/> Piercings Where? _____ <input type="checkbox"/> Tattoos Where? _____ <input type="checkbox"/> Cancer/Tumor (Explain) _____ <input type="checkbox"/> Other Significant Illnesses/Concerns _____	<input type="checkbox"/> Prostate Problems <input type="checkbox"/> Menstrual Problems <input type="checkbox"/> Urinary Problems <input type="checkbox"/> Currently Pregnant, # weeks _____ <input type="checkbox"/> Abnormal Weight Gain Loss <input type="checkbox"/> Marked Morning Pain/Stiffness <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Visual Disturbances <input type="checkbox"/> Surgeries _____ <input type="checkbox"/> Scars _____ <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Tobacco Use - Type _____ <input type="checkbox"/> Depression / Anxiety <input type="checkbox"/> Spinal Abnormalities <input type="checkbox"/> TMJ Dysfunction <input type="checkbox"/> Medications _____	<p><i>Family History:</i></p> <input type="checkbox"/> Cancer / Type? _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Problems/ Stroke <input type="checkbox"/> Rheumatoid Arthritis <p>Mark painful areas:</p> <div style="display: flex; justify-content: space-around;">   </div>
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Consent For Treatment: I, the undersigned, have voluntarily applied for and agree to participate in treatment with Dr. Ingrid Fullerton. The ultimate responsibility of the fees is that of the undersigned. My signature indicates my understanding and acknowledgement of the foregoing information.

Patient's Signature: _____ Date: _____