

Name_____Social Security _____Drivers License _____

Address _____Age _____Birth Date _____

E - Mail _____Marital Status M S D W

Home Phone _____Work Phone _____Number Of Children _____

Employer _____Job Activities _____

Occupation _____

In case of emergency please contact. _____Relation _____Phone _____

Whom may we thank for referring you to our Center? _____

If you have no symptoms or complaints and are here for wellness services, please check (✓) here _____ "Wish to have Chiropractic Wellness Services" and skip filling in a major complaint below. Otherwise please fill out the full "Patient Entrance Data" form in as much detail as possible.

Purpose of this appointment (major complaint) _____

Date symptoms first appeared _____Was this due to an Automobile Accident Y N Work Accident Y N

Ever had same or similiar condition Y N If yes when and describe _____

Other doctors seen for this condition _____

Present M.D. _____Date of last visit _____Reason _____

Previous Chiropractor _____Date of last visit _____Results Good Fair Poor

Females: Is there any chance you are pregnant? Y N Date last menstrual period ended? _____

As a full spectrum Chiropractic and Holistic Health Center, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this Center, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis you have experienced physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most of the time the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

HAVE YOU SUFFERED FROM ?

Past Current		Occasional Frequent	Past Current		Occasional Frequent	Past Current	Women	Occasional Frequent
☐ ☐	Backaches	☐ ☐	☐ ☐	Allergies	☐ ☐	☐ ☐	Menstrual cramps	☐ ☐
☐ ☐	Neck pain or stiffness	☐ ☐	☐ ☐	Sinus problems	☐ ☐	☐ ☐	Irregular cycle	☐ ☐
☐ ☐	Headaches	☐ ☐	☐ ☐	Frequent colds	☐ ☐	☐ ☐	Light or heavy flow	☐ ☐
	Arms or legs:		☐ ☐	Earaches	☐ ☐	☐ ☐	Miscarriages	☐ ☐
☐ ☐	Radiating pain	☐ ☐	☐ ☐	Noise in the ears	☐ ☐	☐ ☐	Other female problems	☐ ☐
☐ ☐	Numbness	☐ ☐	☐ ☐	Dizziness	☐ ☐		Men	
☐ ☐	Cramps	☐ ☐	☐ ☐	Eye or vision problems	☐ ☐	☐ ☐	Prostate problems	☐ ☐
☐ ☐	Arthritis	☐ ☐	☐ ☐	Diabetes	☐ ☐			
☐ ☐	Gout	☐ ☐	☐ ☐	Low blood sugar	☐ ☐	☐ ☐	Sexually Transmitted Dx	
☐ ☐	Curvature of spine	☐ ☐	☐ ☐	Digestive problems	☐ ☐	☐ ☐	Cancer	
☐ ☐	Bursitis	☐ ☐	☐ ☐	Constipation	☐ ☐	☐ ☐	Stroke	
☐ ☐	Foot trouble	☐ ☐	☐ ☐	Diarrhea	☐ ☐	☐ ☐	Multiple sclerosis	
☐ ☐	Heart problems	☐ ☐	☐ ☐	Kidney or bladder prob.	☐ ☐	☐ ☐	Alcoholism	
☐ ☐	Circulation problems	☐ ☐	☐ ☐	Difficulties with urination	☐ ☐	☐ ☐	Anemia	
☐ ☐	Blood pressure problems	☐ ☐	☐ ☐	Difficulty sleeping	☐ ☐	☐ ☐	Tuberculosis	
☐ ☐	Swelling of the ankles	☐ ☐	☐ ☐	Fatigue	☐ ☐	☐ ☐	Polio	
☐ ☐	Lung or breathing prob.	☐ ☐	☐ ☐	Nervousness or depression	☐ ☐	☐ ☐	Epilepsy	

Please list ANY SIGNIFICANT ACCIDENTS / TRAUMAS you have had in your life time (When were they? The circumstances? What treatment, if any was given?) : _____

Please list ANY SURGERIES / HOSPITALIZATIONS you have had in your lifetime (When they were? The reason(s) for the surgeries? Any Complications?) : _____

Please list any medications you are currently taking and any long term or high dose medications you have taken in the past, the reason for the medication, and the time span on the medication. _____

Lifestyle Choices & Habits

Alcohol (What kind? How often? How many drinks?) ; _____

Coffee (Reg or Decaf? How many cups? What time of day?) : _____

Tobacco (What kind? How much per day?) : _____

Excercise (What kind? Duration? How often?) : _____

Bowel Movements (How many per day? When? Easy or difficult? Loose or hard? Color?) : _____

Sleep : Type (spring, air) and age of mattress : _____

Condition (Good or Worn) : _____ Comfortable or Not : _____

Positions you mostly sleep in : _____ Type, thickness, and number of pillows : _____

Quality of sleep (Number of hours per night? Interuptions per night? Trouble falling asleep or staying asleep?) : _____

On a scale of 0 to 10 rate your stress level : Occupational : _____ Personal : _____

Current weight : _____ Amount **Gained or Lost** (circle) within past year : _____

Are you wearing a heel lift? (Thickness and in which shoe) : _____

Orthotics (Rigid or flexible? Length of time you have worn it? Percent of the day you wear them?) : _____

Family Health Profile:

At our Chiropractic Center we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please describe below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brothers _____

Sisters _____

Others _____

What do you want to accomplish at ABA Family Chiropractic Center? What are your goals?

1) _____ 3) _____

2) _____ 4) _____

What percent are you committed to getting and staying well? _____

The statements made on this form are accurate to the best of my recollection, and I agree to be examined at ABA Family Chiropractice Center for further evaluation : _____

(Signature)

SYMPTOM SURVEY FORM - PAGE 5

Use the letters listed below to indicate the type and location of your pain and sensations

KEY

A = ACHE

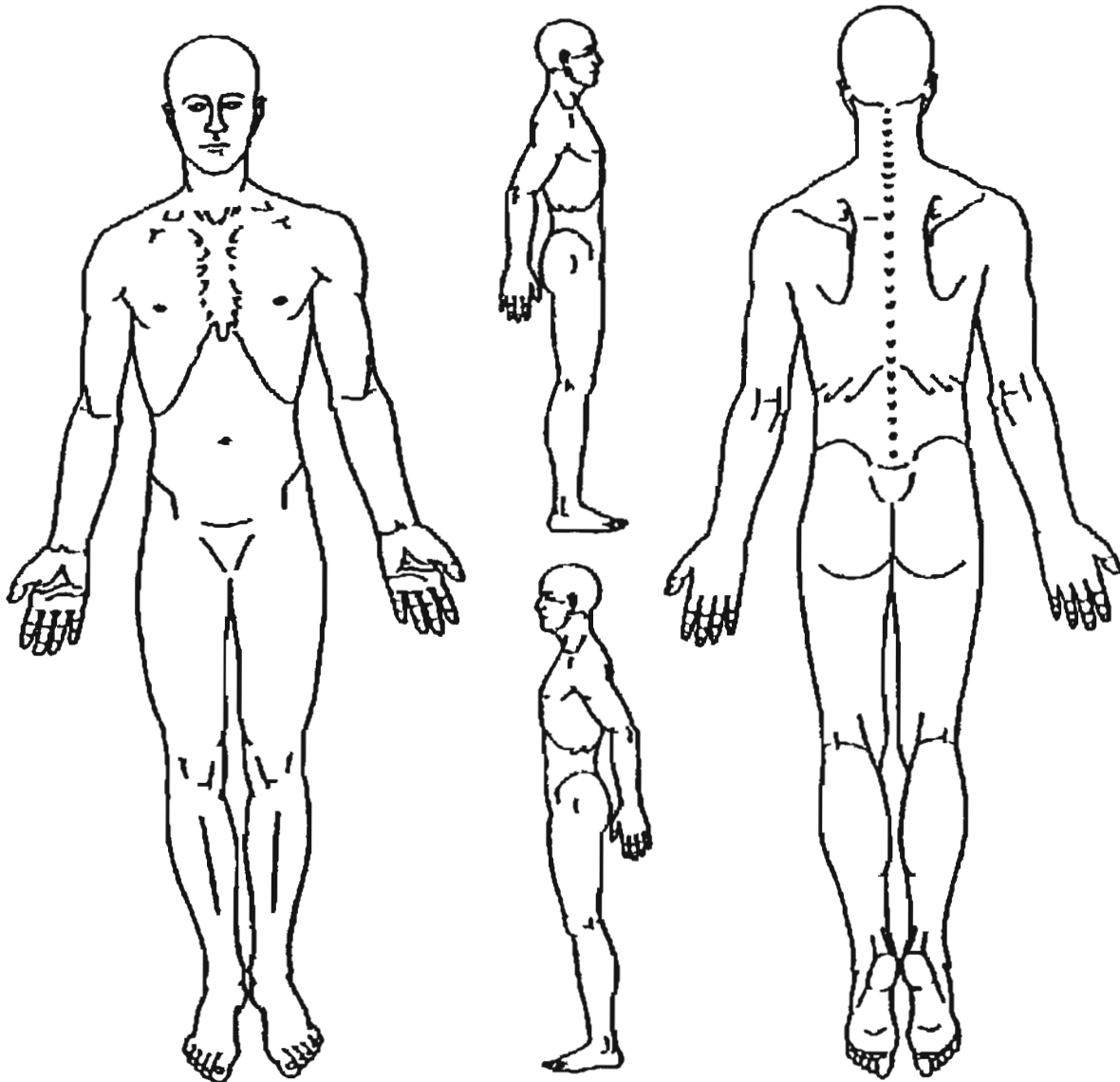
B = BURNING

S = STABBING

N = NUMBNESS

P = PINS & NEEDLES

O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN

SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____

Date _____

FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Patient _____ DATE: _____

Please review the below-listed diseases and conditions and indicate those that are current health problems of a family member. Leave blank those spaces that do not apply. If you require more space use the reverse side of this form.

CONDITION	FATHER Age()	MOTHER Age()	SPOUSE Age()	BROTHER(s) Age() Age()		SISTERS(s) Age() Age()		CHILDREN Age() Age() Age()		
Arthritis										
Asthma-Hay Fever-Allergies										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problem										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pres./ High Cholesterol										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neck Problems										
Neuralgia										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										

If any of the above family members are deceased, please list their age at death and cause:
