PowerSource CHIROPRACTIC

Name:_____ Date of Birth: _____ Age: _____

Your Address: _____ City: _____

State: _____ Zip: _____ SS #: _____ Cell #: _____

Name of Employer: _____ Home #: _____

Marital Status: _____ Referred By: _____

Email _____ How Many Children Do You Have? _____

What Are Their Ages? _____

Have You Or Any Other Members of Your Family Received Chiropractic Care?

How Long Has It Been? _____

Emergency Contact: _____ Phone #: _____

Who Is Responsible For Your Bill? _____

Purpose Or Reason For Today's Appointment _____

How Often Do You Drink Alcoholic Beverages?_____

Do You Smoke? How Much? _____

Do You Exercise? How Much? _____ Type? _____

Do You have Any Allergies Specify: _____

Medication List

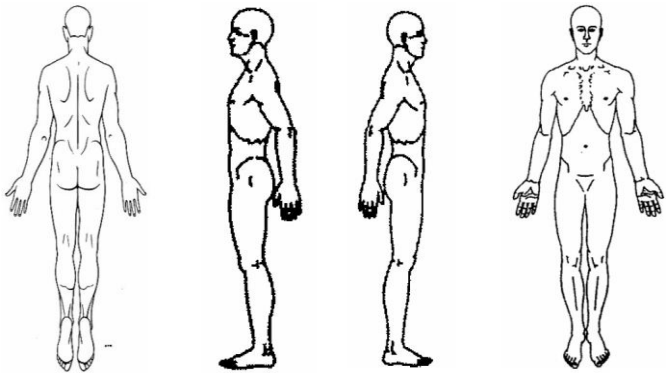
Name of Medication	Name of Vitamins	Date Started	Date Stopped

Date:_____ Patient Name:_____ Account #:_____

PATIENT HISTORY

Using the letters below, please show where you are experiencing all of your complaints on the diagram:

A. Ache
B. Burning
C. Cramping
D. Dull Pain
F. Stiffness
N. Numbness
R. Throbbing
S. Soreness
T. Tingling
X. Sharp Pain



Do you currently have pain and/or difficulty performing any of the following activities? (Type Y if Yes)

Walking	Kneeling	Grooming	Driving
Bending	Sitting	Standing	Exercising
Sleeping	Lifting	Running	Housework

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1. Have you ever had the condition(s) in the past?

If Yes, dates? _____

If yes, please indicate if any treatment was received and what type of treatment:

Hospitalization _____

Chiropractic care_____

Medical doctor / specialty provider _____

2. Have you ever lost time from work due to your condition(s)?

3. Are you pregnant?

4. What was the first day of your last menstrual cycle? _____

5. Number of pregnancies? _____ Number of miscarriages? _____

Systems Review

In the left-hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had in the past. If neither apply, mark (NA). Do not leave any blanks.

_____ High Blood Pressure
_____ Dizziness / Fainting
_____ Insomnia
_____ Low Resistance
_____ Tension
_____ Confusion
_____ Fatigue
_____ Ulcers
_____ Eye/Vision Problems
_____ Ear/Hearing Problems
_____ Difficulty Breathing
_____ Heart Problems
_____ Loss of Bladder Control
_____ Constipation
_____ Diarrhea
_____ Digestion Problems
_____ Nausea
_____ Female Problems
_____ Prostate Problems
_____ Diabetes
_____ Hands / Feet Cold
_____ Loss of Memory
_____ Nervousness
_____ Sweaty Palms
_____ Speech Difficulty
_____ Anxiety
_____ Depression
_____ Irritability

Anyone in your family have or had:

___ stroke ___ arthritis
___ cancer ___ hypertension
___ heart problems ___ diabetes

Please Type Y if you have any of the following:

_____ General	Weight changes, fatigue, anorexia, weakness, fever, chills, changes in activity
_____ Skin	Rashes, eruptions, changes in wart or moles, pigmentation changes, bruises, itching, hair loss, nail changes
_____ Head	Trauma, headaches, dizziness, light headed
_____ Eyes	Changes in acuity photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge
_____ Nose	Rhinorrhea, Epistaxis, allergies, airway obstruction
_____ Mouth & Throat	Ulcers, tooth pain/extractions, temporomandibular joint (TMJ) pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat
_____ Neck	Stiffness, lumps / swelling / masses, pain
_____ Lungs	Cough (productive / nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats
_____ Cardiac	Palpations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope
_____ Vascular	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever
_____ Breasts	Self-examination frequency/results, pain, nipple discharge, lumps/masses, skin dimpling
_____ Gastrointestinal	Unusual diet, sysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemasis, stool color changes,hematures, sexually transmitted diseases, dyspareunia, scrotal swelling
_____ Genitournary	Polyuria nocturia, oliguria, dysuria, uregency, incontinence, urine color change
_____ Endocrine	Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsuitism, menstruation, history, pregnancy history,dysmenorrheal, premenstrual syndrome, climacteric
_____ Hematopoietic	Anemia, abdominal bleeding, lymph node enlargement,/pain
_____ Musculoskelatal	Bone/joint pain, swelling, joint deformity, trama, restricted ROM, weakness, atrophy
_____ Neurological	Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, parasthesia
_____ Psychological	Mood swings, depression, anxiety, phobias

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s).

Problems List

Dr. Name/Facility Problem TXT received When to When

1._____
2._____
3._____
4. _____

	1st Complaint	2nd Complaint	3rd Complaint	4th Complaint	5th Complaint
Complaint:					
When did it start?					
On a scale of 1 -10 1 = mild 5 = moderate 10 = severe Rate your pain levels:	Current:	Current:	Current:	Current:	Current:
	Average:	Average:	Average:	Average:	Average:
	At Best:	At Best:	At Best:	At Best:	At Best:
	At Worst:	At Worst:	At Worst:	At Worst:	At Worst:
What % of the time does it occur?					
When does it occur most? AM, PM or Night?					
How long does it last? Minutes? Hours? Days?					
What makes it better?					
What makes it worse?					

Other providers seen for the same condition:_____

Who is currently your

Chiropractor**:**_____

Primary Care Physician:_____

Physical Therapist: _____

Dentist: _____

Massage Therapist: _____

Personal Trainer: _____

Acupuncturist: _____

Health Club:_____

Other:_____

Doctor Signature:

_____