Mink Chiropractic

Here For Your Health

How did you hear about our office? _____

Have you ever been under chiropractic care? ❑No ❑Yes. If yes, When: _____ Reason: _____

Patient Data (print legibly)

Name _____ Email _____

For general office announcements ONLY.

Address _____ City _____ State _____ Zip _____

Phone (Cell) _____ (Home) _____ (Work) _____

Age _____ Birth Date _____ Sex ❑M ❑F Occupation _____ Hrs worked per week _____

Emergency Contact _____ Relationship _____ Phone _____

Current Complaints

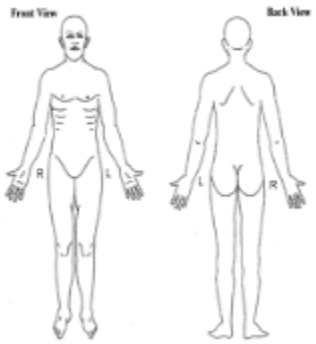
Reason for Visit _____

Is this condition due to an accident? ❑ No ❑Yes. If yes what type? ❑Auto ❑Work ❑Home ❑Other _____

Have you seen other Healthcare Providers for this condition? ❑No ❑Yes _____

Healthcare Provider _____

Mark an X on the picture where you have pain or discomfort.



When did your symptoms first appear? _____

What caused this complaint or how did you do it? _____

What aggravates or makes the condition worse? _____

Is this condition getting progressively worse: ❑Yes ❑No ❑Uncertain _____

What relieves or makes the condition better? _____

Type of pain or discomfort: ❑Sharp ❑Dull ❑Ache ❑Numbness ❑Shooting ❑Tight ❑Burning ❑Tingling ❑Swelling ❑Stabbing ❑Itching ❑Throbbing ❑Other _____

Overall Frequency of complaint: ❑Constant 100% of the time ❑Frequent 75% ❑Intermittent 50% ❑Occasional 25%

Does it interfere with: ❑Work ❑Sleep ❑Daily Routine ❑Recreation

Circle the severity of your pain at its BEST and at its WORST.

Use the scale of <u>Zero (no pain)</u> to <u>10 (severe pain)</u>

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 1 2 3 4 5 6 7 8 9 10

How long has it been since you *really* felt good? _____

What are your hobbies (indoors & outdoors)? _____

How much time do you sit using the computer at work? _____ At home? _____

What makes you stressed? _____ How do you relieve it? _____

Personal Wellness Goals

<u>List 3 goals you want to achieve through chiropractic care</u>.

1. _____
2. _____
3. _____

Health History

Please check each of the conditions that you have now or had in the past.

- ❑AIDS/HIV
- ❑Alcohol/Drug Abuse
- ❑Allergies
- ❑Anemia
- ❑Anorexia
- ❑Arthritis
- ❑Arm Pain/Tingling
- ❑Asthma
- ❑Bleeding Disorders
- ❑Breast Lump
- ❑Bulimia
- ❑Cancer
- ❑Chemotherapy/Radiation
- ❑Diabetes
- ❑Digestive Problems
- ❑Dizziness/Vertigo
- ❑Emphysema
- ❑Epilepsy
- ❑Gout
- ❑Hand Pain/Tingling
- ❑Headaches
- ❑Heart Attack/Stroke
- ❑Heart Surgery/Pacemaker
- ❑Heart Murmur
- ❑Herniated Disk
- ❑Hernia
- ❑Hepatitis
- ❑High/Low Blood Pressure
- ❑High Cholesterol
- ❑Jaw Pain
- ❑Kidney Disease
- ❑Liver Disease
- ❑Loss of Sleep
- ❑Lower Back Problems
- ❑Mid Back Problems
- ❑Migraines
- ❑Multiple Sclerosis
- ❑Neck Pain
- ❑Osteoporosis/Osteopenia
- ❑Parkinson's Disease
- ❑Psychiatric Care
- ❑Sciatica
- ❑Shingles
- ❑Shoulder Pain/Tingling
- ❑Stroke
- ❑Suicidal
- ❑Thyroid Problems
- ❑Tuberculosis
- ❑Tumors/Growths
- ❑Ulcers/Colitis
- ❑Pain that wakes you up at night
- ❑(Men) Prostate Conditions

For Women:

Is there a chance you are Pregnant? ❑No ❑Yes How many weeks? _____
Are you nursing? ❑No ❑Yes
Are you taking birth control pills? ❑No ❑Yes
Do you experience painful periods? ❑No ❑Yes Where is the pain? _____
Do you have irregular cycles? ❑No ❑Yes
Do you have breast implants? ❑No ❑Yes
Number of pregnancies? _____ Number of births? _____

Injuries/Hospitalizations: **Description** **Date**

Falls _____
Head Injuries _____
Broken Bones/Dislocations _____
Surgeries _____

Lifestyle Habits:

Tobacco (# /day) _____ Coffee (cups/day) _____ Sleep (hours/day) _____ Water (oz/day) _____
Alcohol* (drinks/day) _____ Tea (cups/day) _____ Soft drinks (cans/day) _____ ❑Diet or ❑Regular

*1 Drink= 1.5 oz liquor, or 12 oz beer, or 6 oz wine

Exercise: Type _____ Frequency _____
_____ _____

Family History

Family Member Relation:	**Health Problem:**

Medications or Supplements Taken Now: prescription, nonprescription, vitamins, minerals, herbs, etc.

Name:	**Purpose:**	**How Long Taken?**

Your Height: _____ Your Weight: _____