ADIRONDACK CHIROPRACTIC
James G. Kolwaite D.C.

587 Main St. NY Mills
315-768-7578

Name____ Home Phone___________________Date______________

Address____Cell Phone_________________________________

City, State, Zip____Birthdate____________________________

Age_______ SS#__________________________ E-mail______________________________ Marital Status, M W D S

Spouses Name__________________ No. of children_________ What do prefer to be called? ___________________________

Occupation____________________________ Employer____________________ Employer Phone_____________________

Employers Address ____ (Female) Pregnant? NO YES

Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend, Family member, advertisement, phone book, other, Name-_________________________

Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime?_______________When was your last complete spinal examination including x-rays? __________________________

Have you ever been told you have a spinal curvature, spinal arthritis, or other spinal problem? ____________________________

Do you ever hear popping or cracking when you move your head or neck? YES NO

Please list any medications you are taking____

Please list any surgeries you have had____

Trauma, auto accidents and work injuries can cause serious spinal problems. When was your most recent injury at home? __________
At work? ____________ Car accident?______________________ Slip or fall?____________________________________

History of Heart disease, Diabetes, Cancer, Digestive problems, Asthma, Allergies, Headaches, Broken bones, Osteoporosis, other conditions?____

Do you smoke? YES NO, Do you exercise? YES NO, Sleeping position: BACK SIDE STOMACH, Right/Left Handed

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Current Symptoms / reason for visit ____

How long?______________________ How did it happen?____

Symptoms: Constant, Intermittent, Sharp, Dull, Stabbing, Radiating Y N Arms?_____ Legs?_____

Aggravating factors? _________________________ Relieving factors: Ice, Heat, Rest, Medication, Other_____________

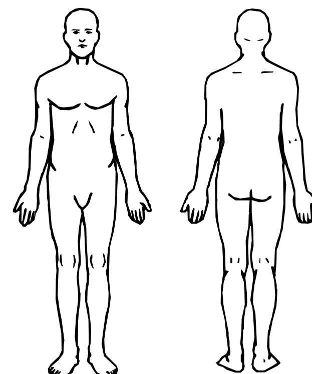
Similar problem in the past? NO YES_______________________

Course of symptoms, Getting better? Worse? No change?

Pre-existing? NO YES

Rate your current pain below: please make 2 marks
(1 to show current pain and 1 to show pain at its worst.)

1_________________5_________________10
best worst possible



* Please indicate where your symptoms are on the figures to the right: >>>