CHAMPION HEALTH CHIROPRACTIC

Name _____ Today's Date_____
Birthdate_____ Age_____
Address _____ City _____
State _____ Zip _____
Cell Phone _____ Work Phone _____
Gender ❑ M ❑ F
Significant Other's Name _____
Kid's Names and Ages_____
Your Employer _____ Type of Work _____
E-Mail Address _____

Emergency Contact _____ ph # _____
Relationship to Patient _____
Name of Family Doctor(s)_____
Who may we thank for referring you to this office? _____

PRESENT COMPLAINTS

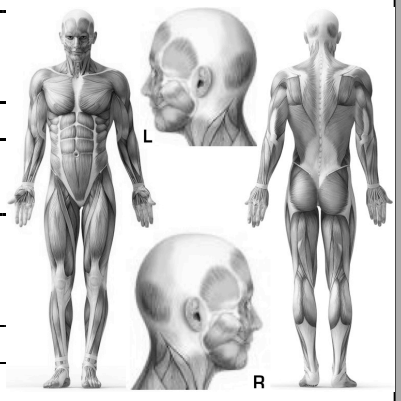
Please Identify the Condition(s) that brought you to this office:
Primary:_____ 2ND: _____
3RD: _____ 4TH: _____

On a Scale of 1 to 10 with 10 being the worst pain and Zero being no pain, rate your above complaints by **circling** the number:

Primary or Chief Complaint is: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10
Second Complaint is: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10
Third Complaint is: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10
Fourth Complaint is: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

When did the Problem(s) begin? _____
When is the problem at its worst? ____AM ____PM ____Mid-Day ____Late PM
How long does it last? _____
How did the injury happen? _____

Has this been treated by anyone in the past? **Y/N**
Type of Treatment: _____
Results: _____
Have you Been to a Chiropractor Before? **Y/N**
What was your experience like? _____



PLEASE **MARK** the areas on the Diagram with the following letters to describe your symptoms:

R= Radiating **B= B**urning **D= D**ull **A= A**ching **N= N**umbness **S= S**harp/**S**tabbing **T= T**ingling

What Relieves your Symptoms? _____
What makes your Symptoms worse? _____

ARE YOU PREGNANT? Y/N

Identify any other injury(s) major or minor, the doctor should know about:_____
_____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	**EFFECT:**			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

Quadruple Visual Analogue Scale: If you have more than one complaint, please answer each questions for each individual comlaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Headaches Neck Low back

Example: No pain -1——2——(3)——4——(5)——6——(7)——8——9——10 – Worst possible pain

1. What is your pain **Right Now**

No pain -1——2——3——4——5——6——7——8——9——10 – Worst possible pain

2. What is your **Typical or Average pain**

No pain -1——2——3——4——5——6——7——8——9——10 – Worst possible pain

3. What is your pain level at its **Best** (How close to "0" does your pain get at its best)?

No pain -1——2——3——4——5——6——7——8——9——10 – Worst possible pain

4. What is your pain level at its **Worst** (How close to "10" does your pain get at its worst)?

No pain -1——2——3——4——5——6——7——8——9——10 – Worst possible pain

_____

GENERAL HEALTH HISTORY

Patient Name_____ ***Mark the conditions that apply to you.***

Past	Present		Past	Present	
		Headaches			Urinary Problems
		Migraines			Easy Bruising
		Shortness of Breath			Tobacco Use
		Allergies / Asthma			Dental Problems
		Medication Side Effects			Fibromyalgia
		Diabetes			Blood Thinner use
		Hands or Feet cold			HIV Positive
		Muscle aches			Cancer
		Trouble Walking			Depression
		Leg / Foot Numbness			Alcohol Use
		Fainting			Gall Bladder Trouble
		___High or ___Low Blood Pressure			Stroke History
		Ringing in Ears			High Cholesterol
		Ear Problems			TMJ Dysfunction
		Sleeping Problems			Digestive Problems
		Vision Problems			Pain all Over
		Thyroid Problems			Tension / Irritability
		Liver Disease			Chest Pains
		Kidney Problems			Heart Pacemaker
		Light Bothers Eyes			Heart Problems
		Other			

_____

PAST HISTORY

1. List any medications you are taking: _____
_____
2. Please list all doctors you are currently seeing:_____
_____
3. If you have been diagnosed with any of the following conditions, please indicate with a P for in the Past, C for Currently have, or N for Never Had:

___Broken Bone ___Dislocations ___Tumors ___Rheumatoid Arthritis ___Fracture
___Disability ___Cancer ___ Heart Attack ___Osteo-Arthritis ___Diabetes
___Cerebral Vascular ___Other Serious Conditions: _____

4. List any past auto collisions:_____Was any Care Received? _____
5. List any past work injuries: _____Was any Care Received? _____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____
_____
8. Please list any past hospitalizations and surgeries: _____
_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis
□ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis
□ Other_____

Is there any other family history you want us to know?_____
_____