

Welcome to **The Healthy Place** *Pain Relief and Wellness*

Your Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Let's start where it counts... What is your Major pain or symptom? \_\_\_\_\_

Its it  Constant  Frequent  Occasional  First time  Getting worse  Getting better

I've had it since \_\_\_\_\_ Ever had it before?  No  Yes  Many times

What activity makes it worse? \_\_\_\_\_ Better? \_\_\_\_\_

Other symptoms and pains now or recently: \_\_\_\_\_

Other chiropractors? \_\_\_\_\_ Positive experience? \_\_\_\_\_

Other types of doctors or therapists? \_\_\_\_\_ Positive experience? \_\_\_\_\_

Now the Mundane but necessary information:

Street Address \_\_\_\_\_

City/Town: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

For FREE health info: Your E-mail: \_\_\_\_\_

Don't worry. I won't inundate you, and none of this information ever leaves this office.

Gender M F ... Your Birthday \_\_\_\_\_ Age today \_\_\_\_\_

Marital Status: S M D W Spouse's name \_\_\_\_\_ # of kids? \_\_\_\_\_

**Whom may we thank for referring you?** \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer address \_\_\_\_\_

Please describe your job duties (not your title) \_\_\_\_\_

Your favorite recreation: \_\_\_\_\_ How often? \_\_\_\_\_

What else do you do repeatedly at work or at home? \_\_\_\_\_

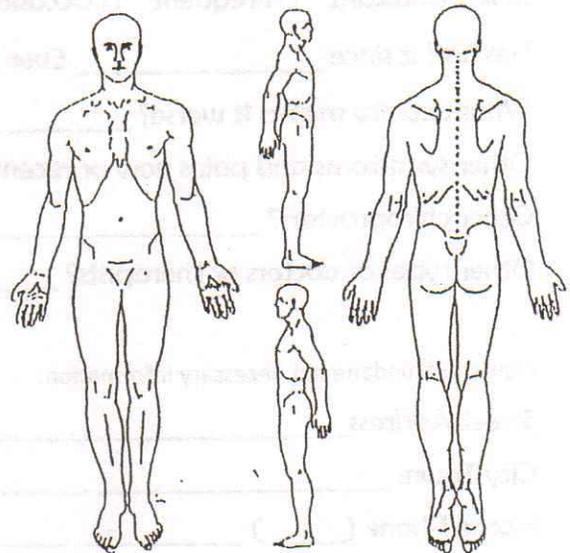
Please turn over... The reverse side of this form is just a short checklist. You are almost done.

Please let us know about any health problems you have had in the past. Please be open, and do not assume that something may not be related. You'd be surprised what can get you!

For the "yeses", we'll cover the details in the consultation.

- Auto accident(s) – EVER! ...
- Anything that resulted in a broken bone
- On-the-job-injury
- Injured in the military
- High school or college contact sports
- Recent infections (last 3 years)
- Chronic illness, now or ever
- Heart problems
- Kidney problems
- Lung problems
- Any kind of cancer
- Eating problems (Does something eat you?)
- Digestive problems
- Intestinal or elimination problems
- Injuries to your feet
- Problems getting born (YOUR Birth)
- Are you diabetic?

Please mark your areas of pain  
 P = PAIN      Ten = Tenderness  
 N = Numb      Ting = Tingling  
 O = Other (describe)



- Do you Smoke?  Yes  No
- Does anyone else in your family (Blood relatives only) have anything similar to your present problem? Who? \_\_\_\_\_
- List ALL medications you take now \_\_\_\_\_
- Surgeries?(Ever!) \_\_\_\_\_
- What kind of exercise do you do? \_\_\_\_\_
- WOMEN: Are you pregnant?  No  Yes
- WOMEN: Did you have trouble giving birth? ...  Yes  No  I have no children
- Everybody: Anything unusual that I should know about? \_\_\_\_\_



Are you Claiming:  Medicare     Hurt on your job     Car Crash (NY-registered car)

*If you claim none of those three, then you are done with the paperwork.*

*If you are claiming one, we have a bit more to do.*