Atlanta
Chiropractic & Wellness Center

FULL NAME_____ DATE_____ AGE_____ HEIGHT_____ WEIGHT_____

WHAT IS YOUR CHIEF COMPLAINT?_____

NO PHYSICAL COMPAINTS AT THIS TIME: ☐

☐ Confusion	☐ Neck Pain	☐ Lower Back Pain
☐ Depression	☐ Neck Restriction	☐ Lower Back Stiffness
☐ Dizziness	☐ Neck Stiffness	☐ Constipation
☐ Blurred/Double Vision	☐ Pins & Needles in Arms: Right Left Both	☐ Pins & Needles in Legs: Right Left Both
☐ Ears Ringing/Buzzing	☐ Pins & Needles in Hands: Right Left Both	☐ Other:
☐ Eye Strain/Pain	☐ Shoulder Pain: Right Left Both	
☐ Fainting	☐ Elbow Pain: Right Left Both	
☐ Fear	☐ Hand Pain: Right Left Both	
☐ Headache	☐ Knee Pain: Right Left Both	
☐ Head Seems Heavy	☐ Ankle Pain: Right Left Both	
☐ Irritability	☐ Foot Pain: Right Left Both	
☐ Loss of Memory	☐ Upper Back Pain	
☐ Loss of Smell	☐ Upper Back Stiffness	
☐ Loss of Taste	☐ Rib Pain	
☐ Mental Dullness	☐ Mid-back Pain	
☐ Nervousness	☐ Mid-back Stiffness	
☐ Tension	☐ Chest Pain	
☐ Unbalanced	☐ Feet/Hands Cold	

HAVE YOU BEEN INVOLVED IN AN AUTO ACCIDENT IN THE LAST YEAR? YES ☐ NO ☐

IF SO, IS THIS CONDITION RELATED? YES ☐ NO ☐

HAS THE PROBLEM INTERRUPTED YOUR SLEEP? YES ☐ NO ☐

DOES ANYONE IN YOUR FAMILY HAVE THE SAME OR SIMILAR CONDITION? YES ☐ NO ☐

IF SO, WHO: _____

LIST ANY OTHER DOCTORS OR THERAPISTS THAT YOU HAVE SEEN FOR THIS COMPLAINT:

_____ SPECIALTY:_____

RELEVANT MEDICAL HISTORY: (Please check the conditions you have or have had previously)

☐ Arthritis	☐ Epilepsy	☐ Muscular Dystrophy
☐ Asthma	☐ Fibromyalgia	☐ Neck Pain or Spasms
☐ Anemia	☐ Hand or Wrist Pain	☐ Neuritis
☐ Back Pain or Spasm	☐ Headaches	☐ Numbness
☐ Cancer	☐ Heart Problems	☐ Polio
☐ Concussion	☐ Hepatitis	☐ Rheumatic Fever
☐ Convulsion	☐ High Blood Pressure	☐ Sinus Trouble
☐ Diabetes	☐ HIV	☐ Sciatica
☐ Digestion Problems	☐ Measles	☐ Tuberculosis (TB)
☐ Dizziness	☐ Multiple Sclerosis	☐ Venereal Disease

LIST ANY SURGERIES THAT YOU HAVE HAD AND APPROXIMATE DATES:

1. _____ DATE: _____ DR: _____
2. _____ DATE: _____ DR: _____
3. _____ DATE: _____ DR: _____

FULL NAME_____ DATE_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ☐ NO ☐

ARE YOU TAKING ANY MEDICATIONS FOR THIS OR ANY OTHER COMPLAINT? YES ☐ NO ☐

ARE YOU PREGNANT? YES ☐ NO ☐ IF YES, DUE DATE:_____

FAMILY HISTORY: HEART DISEASE ☐ ARTHRITIS ☐ CANCER ☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐

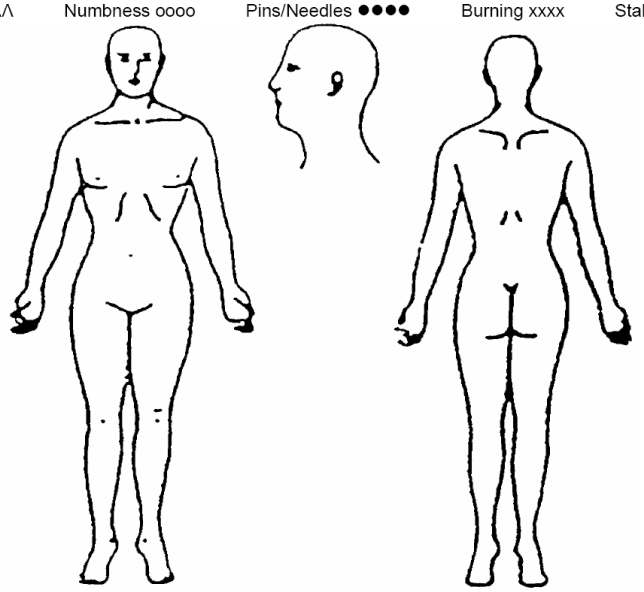
DO YOU: SMOKE: YES ☐ NO ☐ IF YES, AMOUNT PER DAY:_____

DRINK: YES ☐ NO ☐ LIGHT ☐ MEDIUM ☐ HEAVY ☐

DRUGS: YES ☐ NO ☐

SYMPTOMS DIAGRAM

Aches ΛΛΛΛ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



ON A SCALE FROM 1 – 10, 1 BEING THE LEAST AMOUNT OF SYMPTOMS AND 10 BEING THE WORST, PLEASE INDICATE THE SEVERITY REGARDING THE FOLLOWING QUESTIONS:

How bad are your symptoms now?	1	2	3	4	5	6	7	8	9	10
How bad have they been in the past?	1	2	3	4	5	6	7	8	9	10
What are the symptoms at their worst?	1	2	3	4	5	6	7	8	9	10
What are the symptoms at their best?	1	2	3	4	5	6	7	8	9	10
How bad are your symptoms on average?	1	2	3	4	5	6	7	8	9	10

ARE YOU HERE FOR :

RELIEF CARE ☐ (Gets rid of symptoms or pain, but not cause)

CORRECTIVE CARE ☐ (Gets rid of symptoms and corrects cause. Varies in length of time, but is more lasting.)