Chart#___________________

Chiropractic Works

101 Cedar Rock Trace ◊ Athens, GA 30605 ◊ 706-548-8984

Name ____Date_____________________

DOB: _____/______/_______ SS#_______-_______-___________ Email ____

Address ____

Phone: (H) ___________________ (C) _______________________ (W) _____________________

Employer__________________________ Occupation & Job Description____

Emergency Contact Name & Number ____

Please list current medications & dosage. If you aren't taking any, please write none currently.

____

____

Any Allergies? □ No □ Yes (If yes, please list & reaction) ____

Any Surgeries? □ No □ Yes (If yes, please list) ____

____

Past Medical History: (mark all that apply) □Car accident □Heart attack □Congestive heart □A-Fib □Diabetes

□High blood pressure □Cholesterol □Stroke □Cancer □Asthma □COPD □Ulcer □Thyroid □AIDS □TB □other________________

Childhood Illnesses: □Chickenpox □Measles □Mumps □Whooping Cough □Asthma □RSV □Other ________________

Family History: Please mark the condition(s) related to your parents □Adopted/unknown

Mother : □Healthy □Stroke □Cancer □Diabetes □High Blood Pressure □Deceased □Unknown

Father : □Healthy □Stroke □Cancer □Diabetes □High Blood Pressure □Deceased □Unknown

Caffeine(coffee/tea/soda) ______cups/day Alcohol ______/day ______/week other substances _______________

Smoking Status □daily (circle: heavy or light?) □former □never

Review of Systems: (mark all that apply)

GENERAL: □weakness □fatigue/lethargy □trouble sleeping □weight gain □weight loss □increased appetite □ decreased appetite

SKIN: □rash □sore □itching □dry □changes in hair/nails

HEENT: □headache □head injury □dizzy □lightheaded □vision changes □tearing □tinnitus □vertigo □sinus trouble

CARDIOVASCULAR: □chest pain/discomfort □palpitations □edema

RESPIRATORY: □cough □sputum □hemoptysis □dyspnea □wheezing □sleep apnea

GI: □trouble swallowing □heartburn □nausea □constipation □diarrhea □abdominal pain □food intolerance □Crohn's

URINARY: □polyuria □nocturia □urgency □hematuria □infections □stones □incontinence □dribbling

PERIP.VASC.: □leg cramps □varicose veins

MSK: □neck pain □back pain □muscle pain □joint pain □stiffness □swelling □tenderness □redness □limited ROM

NEUROLOGICAL: □fainting □blackouts □seizures □restless legs □weakness □paralysis □numbness □tingling □tremors

ENDOCRINE: □heat intolerance □cold intolerance □excessive sweating □excessive thirst □excessive hunger □change in glove/hat/shoe size

Additional comments: ____

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Notes: