CHIROPRACTIC WORKS

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Athens, GA 30605
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www.chiropracticworks.com

Name: (First) _____ (Last) _____
Age: _____ Birth Date: _____ Gender: Male _____ Female _____
Address: _____
City: _____ State: _____ Zip Code: _____
Cell # (___) _____ Work # (___) _____ Home # (___) _____
E-mail Address: _____@_____
How did you hear about our office? _____

Reason for Visit: ☐Neurofeedback ☐Specific Health Concern ☐Integrated Wellness ☐Chiropractic

Explain your health concern in detail:

_____

_____

_____

_____

Please identify the other health care providers you have seen, treatments, and results:

_____

_____

_____

_____

_____

_____

Any other health concerns you wish for this office to know about?

_____

_____

_____

Sleeping Habits (include how many hours/quality):

_____

_____

Activity Level:

_____

_____

Past Medical History: (Circle all that apply)

Measles	Ear Infections	Upper Respiratory Infection
Mumps	Allergies	Bronchitis
Chicken Pox	Asthma	Eczema
Trauma	Bed Wetting	Motion Sickness
Oculo-motor Problems	Walking Difficulties	Rashes
Learning Difficulties	Colic	Balance
Fever	Anxiousness	Clumsy
Cravings	Food Sensitivities	Constipation
Diarrhea	Influenza	Endocrine
Diabetes	Autoimmune	Cancer
Weight Management	Lyme's Disease	Depression
Seizures	Fear	OCD

Please discuss how circled items were managed (include treatments and outcomes):

_____

_____

_____

_____

Please describe your main reason to participate in this consultation:

_____

_____

_____

Family History:
Please describe in detail your family history. Indicate if parents or siblings experience autoimmune disorder, diabetes, cancer, heart disease, stroke, heart attack, angina, dementia, depression, gastro-intestinal dysfunction, endocrine dysfunction, mental illness, anxiety…please feel free to add any other family health issues:

_____

_____

_____

_____

Diet: Describe your diet over the last 24 hours:

Breakfast:_____

Lunch:_____

Dinner:_____

Caffeine (coffee/tea/soda**)** _____cups/day **Alcohol:** _____/day _____/week

Smoking status: ☐daily (circle: heavy or light?) ☐former ☐never

List all medications and supplements:_____

_____

Were you ever involved in a trauma? ☐No ☐Yes Please describe:

_____

_____

Did you participate in sports as a youth? ☐No ☐Yes
(i.e. football, soccer, gymnastics, baseball, basketball, cheerleading, martial arts, etc…)
Sports: _____

Have you ever been involved in a car accident? ☐No ☐Yes Please describe:

_____

_____

Have you ever been seen for an emergency other than a trauma? ☐No ☐Yes Please describe:

_____

_____

Prior surgeries? ☐No ☐Yes Please describe:

_____

_____

Menarche (Female patients)? ☐No ☐Yes Age: _____

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 □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

Signature of person completing this document: _____
Print Name: _____
Date: _____