McPeak Chiropractic LLC
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Patient Information

Name_____Age_____Date_____

Address_____City_____State____Zip_____

Phone(Home/Cell)_____Date of Birth_____Sex: M / F

Marital Status: S M D W Occupation_____Employer_____

Spouse's Name_____

Is your present condition due to an injury? Y__N__On the job__Auto Accident__Other__

Has this accident been reported? Y__N__To Employer__Auto Carrier__Other__

Do you currently have a general practitioner? Y / N If yes please list_____

May we contact them about this visit? Y / N If yes please provide contact information

GP Address_____

GP Phone_____

Health Report

Reason for seeking care_____

Have you seen any other doctors for this condition: Y / N

If yes please list_____

List any diagnosis and types of treatments received for this condition_____

_____

Have you had a similar accident or injury before? Y / N If yes please explain_____

_____

Have you ever received chiropractic care before? Y / N If yes please explain_____

_____

Have you been treated for any condition by any other physician within the last year? Y / N

If yes please explain_____

_____

Are you currently taking any medications? Y / N Please list_____

_____

Please list any conditions for which you are taking medication_____

_____

Please list any surgeries and the dates on which they were performed_____

_____

Family History

List any health conditions, age of death, and cause of death for the following:

Mother_____

Father_____

Siblings_____

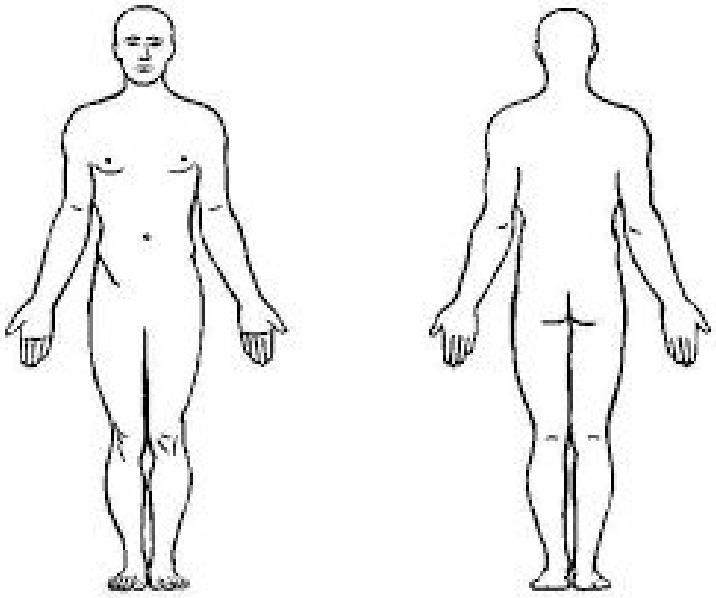
Grandparents_____

Are you a smoker? Y / N How often _____Drink Alcohol? Y / N How often_____Do you take any illegal drugs? Y / N Which and how often?_____How many caffeinated drinks per day do you consume?_____Do you take any vitamins/supplements? Y / N Please list_____

Please circle the degree of pain you are currently experiencing 0 equaling no pain and 10 equaling extreme pain (i.e surgery with no anesthetic)

0 1 2 3 4 5 6 7 8 9 10

Using the following symbols please indicate on the picture below where you are experiencing pain: Numbness: === Dull Ache: 000 Burning: xxx Sharp/Stabbing: /// Pins/needles: +++ Other: ^^^



When did this condition begin?_____

What were you doing at the time this condition began?_____

_____

Which activities aggravate your pain?_____

Which activities lessen your pain?_____

Is this condition worse during certain times of the day? Y / N If yes, when?_____

Is this condition interfering with? Work___sleep___routine___other___

Please explain_____

Please mark each item below for any conditions that you presently have or have had previously.

General Symptoms
__Convulsions
__Dizziness
__Fainting
__Headache
__Nervousness
__Numbness
__Wheezing

Muscles & Joints
__Low back problems
__Pain between shoulders
__Neck problems
__Arm problems
__Leg problems
__Swollen joints
__Painful joints
__Stiff joints
__Sore Muscles
__Weak Muscles
__Walking Problems
__Sprain/Strain

Cardiovascular
__High blood pressure
__Heart attack
__Pain over heart
__Poor circulation
__Heart trouble
__Rapid heart
__Slow heart
__Strokes
__Swelling ankles
__Varicose veins

Ear/Nose/Throat
__Earache
__Ear noises
__Enlarged thyroid
__Frequent colds
__Hay fever
__Nasal blockage
__Nose bleeds
__Pain behind eyes
__Poor vision
__Sinusitis
__Sore throat
__Tonsilitis

Gastrointestinal
__Belching/gas
__Colon problems
__Constipation
__Diarrhea
__Excessive hunger
__Excessive thirst
__Gall bladder trouble
__Hemorrhoids
__Liver/gall bladder
__Nausea
__Abdominal pain
__Ulcer
__Poor appetite
__Poor digestion
__Vomiting
__Vomiting blood
__Black stool
__Bloody stool
__Weight loss/gain

Respiratory
__Asthma
__Chronic cough
__Difficulty breathing
__Spitting blood
__Spitting phlegm

Genito-urinary
__Blood in urine
__Bladder infection
__Frequent urination
__Kidney infection
__Painful urination
__Prostate problems
__Loss of bladder control

Skin or Allergies
__Boils
__Bruising easily
__Dryness
__Eczema/rash/dermatitis
__Hives
__Itching
__Sensitive Skin
__Allergy

For Women Only
__Birth control
__ Hormone replacement
__Cramps/backaches
__Excessive flow
__Hot flashes
__Irregular cycle
__Miscarriage
__Painful periods
__Vaginal discharge
__Breast pain
Are you pregnant at this time? Y / N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation. Patient Signature_____Date_____