

Rosenblum Chiropractic, LLP

NAME _____ DATE _____

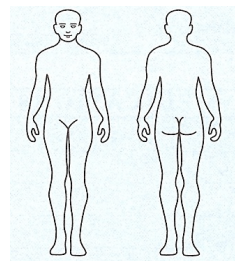
REASON FOR YOUR VISIT TODAY _____

WHEN DID YOUR SYMPTOMS START? _____

WHAT WAS THE CAUSE? _____

ARE YOUR SYMPTOMS THE RESULT OF AN ACCIDENT? YES NO
IF 'YES' WAS IT AT WORK? AN AUTO ACCIDENT?

PLEASE MARK AN 'X' ON THE DRAWING
WHERE YOU FEEL YOUR SYMPTOMS



ON A SCALE OF 1 TO 10 (10 BEING THE WORST PAIN EVER) WHAT IS THE....
AVERAGE INTENSITY OF YOUR SYMPTOMS? _____ TODAY'S LEVEL? _____

CHECK ANY OF THE FOLLOWING THAT DESCRIBE YOUR SYMPTOMS:

- SHARP DULLACHE NUMBNESS TINGLING SWELLING
 SHOOTING BURNING STIFFNESS CRAMPS

HOW ARE YOUR SYMPTOMS CHANGING?

- GETTING BETTER NOT CHANGING GETTING WORSE

THE PAIN INTERFERES WITH MY: WORK SLEEP
 DAILY ROUTINE SOCIAL LIFE

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?

- CONSTANTLY FREQUENTLY OCCASIONALLY INTERMITTENTLY

WHICH ACTIVITIES MAKE YOUR SYMPTOMS WORSE?

- STANDING WALKING BENDING LYING DOWN LIFTING

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? YES NO
IF 'YES' WHEN? _____

WHO HAVE YOU SEEN FOR YOUR SYMPTOMS AND WHEN? _____

WHAT TREATMENT WAS GIVEN? _____

HAVE YOU HAD X-RAYS? CT SCAN? MRI?
 OTHER? _____ DATE OF TEST _____

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ARE YOU PREGNANT? YES NO DUE DATE _____

WHO IS YOUR PRIMARY CARE PROVIDER? _____

HAVE YOU HAD CHIROPRACTIC CARE BEFORE? YES NO WHEN? _____

PLEASE MARK AN 'X' IN THE BOX IF YOU HAVE HAD ANY OF THE FOLLOWING:

ALLERGIES	
ANEMIA	
ARTHRITIS	
ASTHMA	
CANCER	
CHICKEN POX	
DIABETES	
EMPHYSEMA	
EPILEPSY	
FRACTURES	
GOUT	
HEADACHES	
HERPES	
HERNIA	
HEART DISEASE	
HERNIATED DISC	
HIGH BLOOD PRESSURE	

HIGH CHOLESTEROL	
KIDNEY DISEASE	
LIVER DISEASE	
MIGRAINES	
MONONUCLEOSIS	
MULTIPLE SCLEROSIS	
OSTEOPOROSIS	
PACEMAKER	
PARKINSON'S	
PINCHED NERVE	
PNEUMONIA	
PROSTATE PROBLEMS	
RHEUMATIC FEVER	
RHEUMATOID ARTHRITIS	
STROKE	
TUMORS	
ULCERS	

EXERCISE	
NONE	
OCCASIONAL	
DAILY	
HEAVY	
WORK ACTIVITY	
SITTING	
STANDING	
LIGHT LABOR	
HEAVY LABOR	
LIFESTYLE	
ALCOHOL	
COFFEE	
HIGH STRESS	

HEIGHT _____ WEIGHT _____

DESCRIBE ANY SEVERE INJURIES OR MAJOR SURGERIES YOU HAVE HAD:

LIST ANY MEDICATIONS/VITAMINS YOU ARE TAKING:

LIST ANY ALLERGIES YOU MAY HAVE:

HAVE YOU HAD ANY IMMUNIZATIONS IN THE PAST YEAR? IF SO, PLEASE LIST:

HAVE YOU EVER SMOKED? _____ IF YES, WHAT YEAR DID YOU START? _____

HAVE YOU QUIT? _____ IF YES, WHEN? _____