CoreCare Chiropractic LLC

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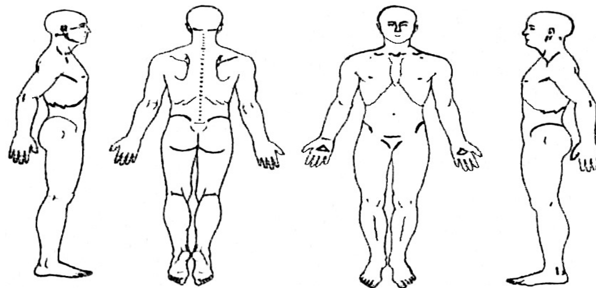
Name:	Age:	Occupation:

1. What brings you in today?
   ____
2. When did this begin? What do you think caused your problem?
   ____
3. Complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine
   How?: ____
4. My problem has gotten **(circle one)**: Better / Worse / Same
5. What makes the problem better? ____
6. What makes the problem worse? ____
7. When is the problem the worst? **(circle)** AM / PM / Both
8. Have you had this in the past? (When?) Have you seen anyone else for this problem? (Who/when?)
   ____
9. Describe problem **(circle all that apply)**

Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling

Cramping Stiffness Swelling Other ______________________

Put an (x) on the diagram where you experience your problem(s)



11. Indicate the severity of the problem at its worst:

1	2	3	4	5	6	7	8	9	10

12. How often do you experience your problem? **(circle**) Occasional / Frequent / Constant
13. Does this travel/radiate? **(circle)** Yes / No If yes, where? ____________________________
14. On a scale of 1 to 10 – how committed are you to correcting this issue? ______/10

Past Medical History

Are there any illnesses in your family? ____Yes ____No If yes, please specify: ____________________
____

Any prior auto, work, or other accidents? ____Yes ____No If yes, please give dates and details: _____
____

General physical activity:____ No regular exercise ____ Light regular exercise ____ Strenuous exercise

How long has it been since you've felt fantastic? ________________________________

Please check the appropriate box if any of the following apply to you (past or present)

GENERAL	Severe	Mod	Mild
Allergy	☐	☐	☐
Dizziness	☐	☐	☐
Ear Problems	☐	☐	☐
Fatigue	☐	☐	☐
Colds/Sinus Infections	☐	☐	☐
Headaches	☐	☐	☐
Nervousness	☐	☐	☐
Nose Bleeds	☐	☐	☐
Numbness	☐	☐	☐
Sore Throat	☐	☐	☐
Sudden Weight Loss/Gain	☐	☐	☐
Tonsillitis	☐	☐	☐
GENITO-URINARY			
Frequent Urination	☐	☐	☐
Inability to Control Urine	☐	☐	☐
Kidney Infection or Stones	☐	☐	☐
Painful Urination	☐	☐	☐
Prostate Trouble	☐	☐	☐
CARDIO-VASCULAR			
High Blood Pressure	☐	☐	☐
Heart Condition	☐	☐	☐
Swelling of Ankles	☐	☐	☐

GASTROINTESTINAL	Severe	Mod	Mild
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Gall Bladder Trouble	☐	☐	☐
Intestinal Trouble	☐	☐	☐
Nausea/Vomiting	☐	☐	☐
Stomach Problems	☐	☐	☐
RESPIRATORY			
Chest Pain	☐	☐	☐
Chronic Cough	☐	☐	☐
Difficulty Breathing	☐	☐	☐
MUSCLE & JOINT			
Ankle Pain	☐	☐	☐
Arm/Shoulder Pain	☐	☐	☐
Elbow Pain	☐	☐	☐
Foot Trouble/Pain	☐	☐	☐
Knee Pain	☐	☐	☐
Leg Pain	☐	☐	☐
Neck Pain	☐	☐	☐
Pain between Shoulders	☐	☐	☐
Lower Back Pain	☐	☐	☐
Rib Pain	☐	☐	☐
Swollen Joints	☐	☐	☐

DO YOU HAVE:	Yes	No
AIDS	☐	☐
Alcoholism	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Mental Disorders	☐	☐
Nervous Breakdown	☐	☐
Polio	☐	☐
Rheumatic Fever	☐	☐
FOR WOMEN ONLY		
Hot Flashes	☐	☐
Irregular Cycle	☐	☐
Lumps in Breast	☐	☐
Painful Menstruation	☐	☐

HABITS

Coffee/Tea ______ Cups/Day
Tobacco _____ Pack(s) / _____
Alcohol _____ Drinks / _____
Sleep _____ Hrs/Night

To the best of my knowledge, the preceding answers to the questions on this form are the complete truth regarding my health history.

Signed: ____ Date: ____________________