

CORBETT CHIROPRACTIC CLINIC

Name: _____ Date: _____

Referred by: _____

Purpose of this appointment (Major complaint) _____

Is condition due to injury or sickness arising from patient's employment? _____

Is condition due to injury from an automobile accident? _____

Date symptoms appear or accident happened ____ / ____ / ____

Are symptoms getting better on its own _____ staying the same _____ or getting worse _____

Patient ever had same or similar condition: _____ If yes, when _____

Is there anything that makes the condition better? _____

Is condition interfering with: work _____ sleep _____ daily routine _____ hobbies _____ other activities _____

How long has it been since you really felt good? _____

What do you believe is wrong with you? _____

Date of last physical examination ____ / ____ / ____ Female: Are you pregnant? _____

What operations have you had? _____

Serious illnesses? _____ Fractured bones _____

Have you been treated for any health condition by a physician in the last year? _____

Have you ever been under Chiropractic care? _____ Doctor _____

Do you suffer from or have you ever suffered from: (on a scale of 1-5 (1= mild effect 5 = very severe)) Leave blank if it does not apply to you.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Poor posture | <input type="checkbox"/> Itching | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Kidney infection or stone |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Spinal curvatures | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Prostate trouble |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Excessive menstrual flow |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Colon trouble | <input type="checkbox"/> Sinus infection | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Irregular cycle |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Difficult digestion | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Lumps in breast |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pain over heart | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Nausea | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Colds | <input type="checkbox"/> Slow heart beat | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Deafness | <input type="checkbox"/> Anemia | <input type="checkbox"/> Failing vision |
| <input type="checkbox"/> Swelling of ankles | <input type="checkbox"/> Ear noises | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Bed-wetting |
| <input type="checkbox"/> Cramps or backache | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Difficult breathing | |

Please turn over and complete

Do You:

Take vitamins or minerals? Yes _____ No _____ Think you may need vitamins or minerals? _____

Wear: Heel lifts _____ Arch supports _____

What medication or drugs are you taking? _____

Remarks or additional information _____

Patients Signature _____ Date _____ Guardian Signature _____

FOR OFFICE USE ONLY

1. Location _____

Radiation _____

Onset: (Traumatic – non-traumatic) (Gradual – Sudden) When did you 1st notice this? _____

Have you had it before ? (Yes – No) When? _____

Timing : (Constant - Intermittent) (Better - Morn Noon Night) Anything make it Better? _____ Worse? _____

Character: (Sharp – Dull) (Deep – Superficial) (Mild – Moderate - Severe)

2. Location _____

Radiation _____

Onset: (Traumatic – non-traumatic) (Gradual – Sudden) When did you 1st notice this? _____

Have you had it before ? (Yes – No) When? _____

Timing : (Constant - Intermittent) (Better - Morn Noon Night) Anything make it Better? _____ Worse? _____

Character: (Sharp – Dull) (Deep – Superficial) (Mild – Moderate - Severe)

3. Location _____

Radiation _____

Onset: (Traumatic – non-traumatic) (Gradual – Sudden) When did you 1st notice this? _____

Have you had it before ? (Yes – No) When? _____

Timing : (Constant - Intermittent) (Better - Morn Noon Night) Anything make it Better? _____ Worse? _____

Character: (Sharp – Dull) (Deep – Superficial) (Mild – Moderate - Severe)

HA, Ringing Ears, Dizziness, Blurring Eyes, Loss Memory, Loss Sleep, Loss Energy, Depression, Nervousness