Crater Chiropractic Clinic, P.C.

Michael L. Warren D.C. & Michael M. Powell D.C.

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PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. *The information you provide concern past and present symptoms and diseases assists your doctor in obtaining an early understanding of your state of health*

Name:_____ Date of Birth:_____ Date:_____
Age:_____ Gender:_____ Height:_____ Weight:_____

1. What problems or symptoms are you having?:_____
2. When did your problem(s) begin? SPECIFIC DATE IF POSSIBLE:_____
3. Did your problem(s) begin: Immediately after a specific incident___ Multiple incidents___ Gradually Developed___
4. Describe how your problem(s) began:_____
5. Please describe the character of your current pain (you may choose more than one): Stabbing___ Sharp___ Aches___ Dull___ Soreness___ Weakness___ Throbbing___ Shooting___ Constricting___ Burning___ Tingling___
6. How bad is your pain or ache at the moment? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10 No pain Unbearable pain
7. How often are the complaints present?: Constant (76%-100%)___ Frequent (51%-75%)___ Occasional (26%-50%)___ Intermittent (25% or less)___
8. Is your condition changing?: Worse____ Better____ No Change____
9. What treatment(s) have you received for the present condition?: Surgery____ Medications____ Chiropractic___
10. Have you been treated in the past? Yes__ No__ if yes, by: Chiropractor___ MD___ Therapist___
11. When is the condition worse?: Morning___ Afternoon___ Evening___ Night___
12. When is the condition better?: Morning___ Afternoon___ Evening___ Night___
13. What makes your problem(s) worse?: Nothing___ Laying down___ Walking___ Standing___ Sitting___ Movement/Exercise___ Inactivity___ Ice___ Heat___ Rest___ Other_____
14. What makes your problem(s) better?: Nothing___ Laying down___ Walking___ Standing___ Sitting___ Movement/Exercise___ Inactivity___ Ice___ Heat___ Rest___ Other_____
15. Does the pain radiate to other areas of the body?: Yes___ No___ Location:_____
16. Do you ever experience headaches?: Yes___ No___ How Frequently?_____
17. Have you ever been hospitalized?: Yes___ No___ if yes, when?:_____
18. Have you ever had any surgical procedures performed?: Yes___ No___ if yes, procedure date:_____
19. Are you currently taking any medications (either prescription or over the counter)?: Yes___ No___
20. In the last 5 years have you been in any: Auto accidents? Yes___ No___ Serious falls? Yes___ No___ If yes, when?:_____ Please Describe:_____

21. Do you smoke?: Yes___ No___

22. Do you have annual physicals?: Yes___ No___ Do you have regular dental check-ups?: Yes___ No___

23. When were your last X-rays taken?: Date:_____ By whom?:_____

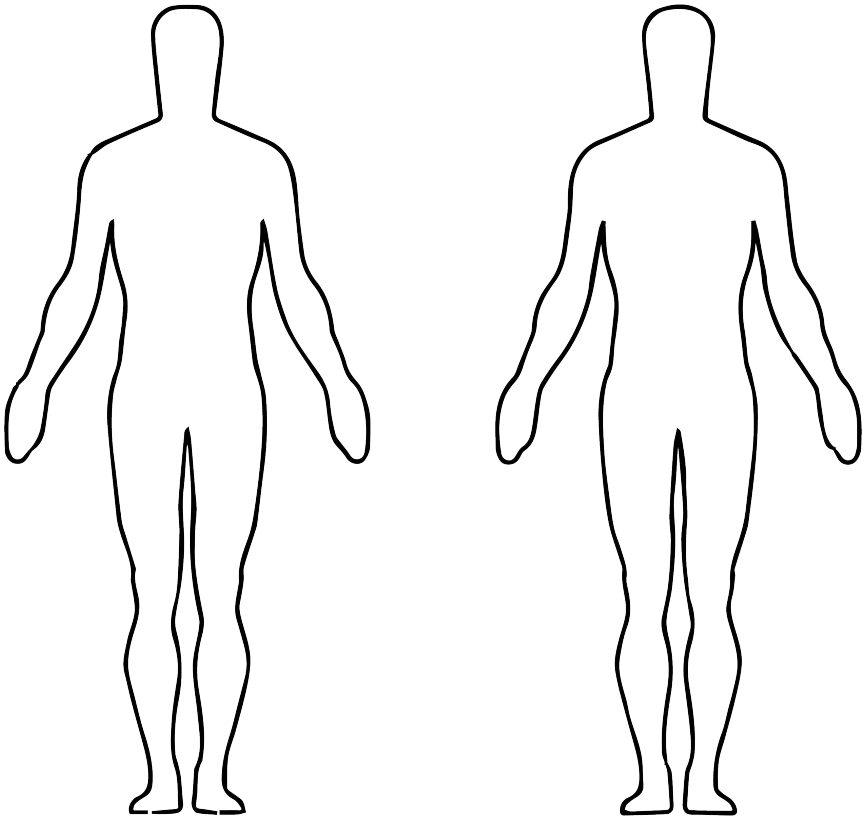
24. If female, are you currently pregnant?: Yes___ No___

25. Do you currently have an M.D.?: Yes___ No___ if yes, Name:_____

26. Have you ever been to a chiropractor before?: Yes___ No___ if yes, Name:_____

27. How did you hear about us?:_____

Mark an "X" on the pictures below where you have pain or other symptoms



FRONT *BACK*

Dr's Notes:

_____

_____

_____

Dr's Signature:_____

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