Name _____ **Date** _____

Life Line
chiropractic & massage

These questions that you are about to answer are very important for the Doctor. They will enable the doctor make a complete and diagnosis, and provide medical documentation (if needed)to your insurance company.

What are your reasons for seeking chiropractic care?

1._____

2._____

3._____

If you only have 1 area of complaint then stop at primary, if you have more than one complaint then continue.

Primary Chief Complaint

1. Location _____
2. When did this begin? _____
3. How did this begin? _____

Circle all that apply to the quality of complaint/pain?

Dull Ache Sharp Shooting Burning Throbbing Deep Nagging Other

Does this complaint/pain radiate or travel to other areas of the body? N Y, to where_____

Do you have any numbness or tingling associated with this complaint/pain? N Y, to where_____

What is the intensity/severity (1 best – 10 worst)? _____

How frequent is the complaint/pain (circle all that apply)? Daily Weekly Monthly Other_____

How long does it last (circle all that apply)? Seconds Minutes Hours Other: _____

What activity makes it worse (circle all that apply)?

Work Exercise Reading Diet Personal Walking Standing Squatting

Twisting Lying down Sitting Bending Lifting Running Driving Other_____

What activity makes is better (circle all that apply):

Home Work Exercise Diet Personal
Walking Standing Squatting Twisting Laying Down Reading
Sitting Bending Lifting Running Driving Other _____

Previous Intervention: What have you tried to fix the problem?

1. Medications: _____ 3. Other Physicians: _____

2. Surgery: _____ 4. Treatments: _____

Secondary Chief Complaint

1. Location _____
2. When did this begin? _____
3. How did this begin? _____

Circle all that apply to the quality of complaint/pain?

Dull Ache Sharp Shooting Burning Throbbing Deep Nagging Other

Does this complaint/pain radiate or travel to other areas of the body? N Y, to where_____

Do you have any numbness or tingling associated with this complaint/pain? N Y, to where_____

What is the intensity/severity (1 best – 10 worst)? _____

How frequent is the complaint/pain (circle all that apply)? Daily Weekly Monthly Other_____

How long does it last (circle all that apply)? Seconds Minutes Hours Other: _____

What activity makes it worse (circle all that apply)?

Work Exercise Reading Diet Personal Walking Standing Squatting
Twisting Lying down Sitting Bending Lifting Running Driving Other_____

What activity makes is better (circle all that apply):

Home Work Exercise Diet Personal
Walking Standing Squatting Twisting Laying Down Reading
Sitting Bending Lifting Running Driving Other _____

Previous Intervention: What have you tried to fix the problem?

1. Medications: _____
2. Surgery: _____
3. Other Physicians: _____
4. Treatments: _____

Tertiary Chief Complaint

1. Location _____
2. When did this begin? _____
3. How did this begin? _____

Circle all that apply to the quality of complaint/pain?

Dull Ache Sharp Shooting Burning Throbbing Deep Nagging Other

Does this complaint/pain radiate or travel to other areas of the body? N Y, to where_____

Do you have any numbness or tingling associated with this complaint/pain? N Y, to where_____

What is the intensity/severity (1 best – 10 worst)? _____

How frequent is the complaint/pain (circle all that apply)? Daily Weekly Monthly Other_____

How long does it last (circle all that apply)? Seconds Minutes Hours Other: _____

What activity makes it worse (circle all that apply)?

Work Exercise Reading Diet Personal Walking Standing Squatting

Twisting Lying down Sitting Bending Lifting Running Driving Other_____

What activity makes is better (circle all that apply):

Home Work Exercise Diet Personal

Walking Standing Squatting Twisting Laying Down Reading

Sitting Bending Lifting Running Driving Other _____

Previous Intervention: *What have you tried to fix the problem?*

1. Medications: _____ 3. Other Physicians: _____

2. Surgery: _____ 4. Treatments: _____

Past Health History

Previous Illness When _____ Type _____

Previous Trauma/Injury _____

Have you had any broken bones? When _____ Where _____

Allergies _____

Current Medications/ with dosage (*Bring list is needed*)

_____

Surgeries Date _____ Type _____

Females Have you had any pregnancies? _____ How many? _____

Vaginal or C Section Complications? _____

Family Health History **(circle all that apply)**

Mother Side

Heart Disease Diabetes

Cancer Arthritis

Autoimmune Disorders

Other_____

Father Side

Heart Disease Diabetes

Cancer Arthritis

Autoimmune Disorders

Social Occupation

Job Description _____

Recreational Activities _____

What are your current primary sources of stress? _____

What do you do in order to manage stress and take care of yourself? _____

What is your exercise routine? _____

Diet; please describe a typical day's diet for you. Don't forget beverages.

Breakfast	Lunch	Dinner	Snacks (what hour)

Tobacco use: Y or N and if yes how much? _____

Caffeine consumption: Y or N and if yes how much? _____ How often?_____

Alcohol consumption: Y or No and if yes how much? _____ How often? _____

Height :_____ Weight: _____

Review of Systems

Circle any conditions that you may have had

General	malaise, fever, night sweats, chills, weight gain or loss
Eyes:	loss of vision, double vision, cataracts
Ears:	hearing loss, ringing in your ears, dizziness
Nose:	sinus infections, frequent bloody nose
Throat:	frequent sore throat, strictures, hoarseness
Heart:	chest pain, irregular heart beat, heart attacks, swelling of the legs or feet
Lung:	difficulty of breathing, shortness of breath, pneumonia, bronchitis, asthma, coughing up blood, tuberculosis
Gastrointestinal:	heartburn, stomach pain, blood in bowel movements, vomiting blood, ulcers, inability to control bowel movements
Genitourinary:	blood in the urine, burning when urinating, sexually transmitted diseases, discharge, inability to control urination

Gynecologic:	female problems, uterus removed, ovaries removed, currently taking birth control pills or estrogen, heavy or irregular mense, pain on intercourse, pain during menstrual cycle
Back:	ruptured disc, car accidents, chronic pain, fractures, strains
Neck:	ruptured disc, car accidents, chronic pain, fractures, strains
Musculoskeletal:	muscle or bone diseases, broken bones, dislocations, osteoporosis, joint instability, chronic pain of an extremity
Neurologic:	loss of sensation, abnormal sensation, tingling, numbness, loss of motor function, decreased strength
Skin:	skin color changes, loss of pigmentation, abnormal moles, bleeding from moles, moles or dark spots increasing in size
Psychiatric:	nervous breakdowns, seeing or hearing things that aren't there, depression, abnormal behavior, taking medication for a psychiatric condition

I have the read the above information and certify it to be true, and correct to the best of my knowledge. I authorize Life Line Chiropractic to provide my consultation to determine my eligibility to receive treatment within this office. By signing your name below you certify the accuracy of your medical and/or accident history and further certify that you present to Life Line Chiropractic for evaluation and/or treatment of a health condition and for no other purposes.

Signature _____ **Date** _____