Askeland Chiropractic & Acupuncture P.C.
PATIENT HISTORY

DATE_____

NAME _____ DATE OF BIRTH_____

ADDRESS_____CITY_____STATE____ZIP_____

PHONE (H)_____PHONE (W)_____ EMAIL ADDRESS _____

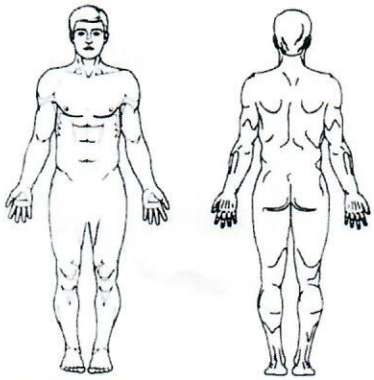
EMPLOYER_____OCCUPATION_____

ADDRESS_____

SPOUSE NAME_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

MAIN REASON FOR YOUR VISIT TODAY:
NECK PAIN HEADACHES MID-BACK
LOW BACK ARM SHOULDER LEG
OTHER_____



PAIN LEVEL: best 1 2 3 4 5 6 7 8 9 10 worst

(PLEASE MARK PAIN LOCATIONS ON THE DIAGRAM)

DATE OF ONSET:_____ GRADUAL SUDDEN PROGRESSIVE OVER TIME

HOW DID THIS INJURY OCCUR?_____

WHAT MAKES YOU FEEL BETTER_____ ***WORSE?***_____

HAVE YOU HAD THIS PROBLEM BEFORE?_____ ***WHEN?***_____

WHAT DID YOU DO FOR THIS CONDITION BEFORE?_____

Previous Chiropractic Care? Y / N ***Chiropractor's Name:***_____

DO YOU HAVE ANY OF THE FOLLOWING?

- ❑ HEADACHES
- ❑ IRRITABILITY
- ❑ CHEST PAIN
- ❑ DEPRESSION
- ❑ DIZZINESS
- ❑ MEMORY LOSS
- ❑ RINGING IN THE EARS
- ❑ DIGESTIVE PROBLEMS
- ❑ LIGHT SENSITIVITY
- ❑ STRESS OR ANXIETY
- ❑ NUMB HANDS OR FEET
- ❑ COLD HANDS OR FEET
- ❑ SHORTNESS OF BREATH
- ❑ DIFFICULTY SLEEPING
- ❑ LOSS OF SMELL OR TASTE

How will you be paying for your first visit services today?
Cash Check Credit Card PI Work Comp

SIGNATURE_____
(Please have your insurance card available for us to photocopy)

Askeland Chiropractic & Acupuncture P.C.

Name:_____ Date:_____

MAJOR COMPLAINT:_____

How long have you had this condition?_____Date of onset:_____

Have you lost workdays? YES / NO If yes, how many?_____

Have you had this or a similar condition before? YES NO If yes, when?_____

Was the injury accident related? NO / Auto accident / Work accident If yes, when?_____

What surgeries have you had? _____

_____

List all drugs you now take (prescription and non prescription):_____

_____

Name other doctors you have seen for this condition:_____

Do you smoke? Y / N Drink Alcohol? Y / N Drinks per week? _____

Family History of: Heart Disease Diabetes High Blood Pressure Stroke

Anything else you would like to tell us that would help in determining your case? _____

_____

What are your health goals?_____

How do you expect to achieve these goals?_____

Please mark if you have had any of these symptoms in the last 12 months: **(please check all that apply)**

____Fractured bones
____Auto Accidents
___0-1 yrs ago
___1-5 yrs ago
___5 yrs or more
____Other accidents, falls
____Arthritis
____Diabetes
____Convulsions, epilepsy
____Skin problems
____Cancer
____Frequent colds, flu
____Depressed
____Irritable
____Anemia
____Allergy, sinus
____Under stress
____Eating disorders
____Trouble sleeping
____Trouble concentrating
____Learning disability
____Mood changes

____Neck pain or stiffness R L
____Numbness/tingling, pain in arms, hands, fingers R L
____Jaw pain or clicks (TMJD) R L
____Difficulty in excessive standing, sitting, riding, bending, lifting, twisting
____Shoulder pain R L
____Dizziness
____Ringing in ears R L
____Hearing loss R L
____Blurred or doubled vision
____Upper back pain, stiffness
____Mid back pain, stiffness
____Lower back pain, stiffness
____Pain with cough, sneeze
____Hip pain R L
____Headaches
____Numbness, tingling, pain in buttocks, legs, feet, toes R L

____Foot trouble R L
____Chest pain, asthma
____Heart problems
____Stroke
____High/low blood pressure
____Varicose veins
____Liver trouble
____Gall bladder trouble
____Digestive problems
____Ulcers
____Hemorrhoids
____Prostate problems
____Impotence
____Kidney trouble
____Menstrual problems (PMS)
____Pregnant (**currently**)
____Bed wetting
____Ear Infections
____ AIDS, HIV