RebarcakChiropractic
PAIN RELIEF CENTER

BASIC INFORMATION

Name ____________________ ______ ____________________ Nickname ____________
First M.I. Last

Date of Birth ______/______/______ Age ______ Gender ❑ M ❑ F Today's Date ____________
mm dd yyyy mm/dd/yyyy

CONTACT INFORMATION

Email ________________________________ Cell Phone (______) - ________ - __________

Address ____________________________ City ______________ State _____ Zip __________

ADDITIONAL INFORMATION

Who can we thank for referring you to our office / how did you hear about our office?

Name ______________________________ ❑ Friend/Family ❑ Coworker ❑ Health Care Provider ❑ Facebook ❑ Google ❑ Website ❑ Insurance ❑ Other

Have you ever been treated by a chiropractor? ❑ No ❑ Yes (name)______________ Last Visit________

Have you seen any other providers for this condition(s)? ❑ No ❑ Yes (name/date)____________________

PRIMARY COMPLAINT Example: "headaches" or "left low back pain"

Your primary complaint ____________________________ Symptoms began ❑ Suddenly ❑ Gradually

Date symptoms began ____________________ Previous episodes ❑ No ❑ Yes (when) __________

Do you know what caused this? ❑ No ❑ Yes (explain) ____________________________________

Check all that apply ❑ Sharp ❑ Dull ❑ Achy ❑ Numb ❑ Stiff ❑ Throbbing ❑ Spasm ❑ Shooting ❑ Burning

Rate the pain on a 0-10 scale (10 being the worst) _____/10 Percent of time in pain ________%

What makes the pain better___________________ What makes the pain worse__________________

Does the pain shoot down the arm or leg? ❑ Yes ❑ No Pain is getting: ❑ Better ❑ Worse ❑ Same

SECONDARY COMPLAINT ❑ No secondary complaint (Skip to other side of this page)

Your second complaint ____________________________ Symptoms began ❑ Suddenly ❑ Gradually

Date symptoms began ____________________ Previous episodes ❑ No ❑ Yes (when) __________

Do you know what caused this? ❑ No ❑ Yes (explain) ____________________________________

Check all that apply ❑ Sharp ❑ Dull ❑ Achy ❑ Numb ❑ Stiff ❑ Throbbing ❑ Spasm ❑ Shooting ❑ Burning

What makes the pain better___________________ What makes the pain worse__________________

Rate the pain on a 0-10 scale (10 being the worst) _____/10 Percent of time in pain ________%

REVIEW OF SYSTEMS

In the past **two weeks**, have you experienced any of the following? (check all that apply)

GENERAL
- ❑ Weight Loss
- ❑ Chills
- ❑ Fever
- ❑ Unexplained Fatigue
- ❑ Night Sweats

MUSCULOSKELETAL
- ❑ Muscle Cramping
- ❑ Joint Swelling
- ❑ Muscle Weakness
- ❑ Muscle Spasms

NEUROLOGICAL
- ❑ Headaches
- ❑ Memory Loss
- ❑ Numbness/Tingling
- ❑ Pain down arm or leg
- ❑ Poor Coordination
- ❑ Reduced Sensation to Touch

EYES
- ❑ Blurry Vision
- ❑ Loss of Vision
- ❑ Spots, Specks, Flickering Lights
- ❑ Sensitivity to light

EARS, NOSE, THROAT
- ❑ Earache
- ❑ Nasal Congestion
- ❑ Vertigo
- ❑ Difficulty Swallowing
- ❑ Jaw Pain

HEART AND LUNGS
- ❑ Chest Pain/Tightness
- ❑ Shortness of Breath
- ❑ Palpitations
- ❑ Swollen Legs or Feet
- ❑ Cough or Wheezing
- ❑ Pain with Exertion

GASTROINTESTINAL
- ❑ Nausea
- ❑ Vomiting
- ❑ Indigestion
- ❑ Abdominal Pain
- ❑ Bowel Incontinence
- ❑ Loss of appetite

GENITOURINARY
- ❑ Painful Urination
- ❑ Urinary Retention

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Itching
- ❑ Blisters

❑ I have not had any of the symptoms listed above in the past two weeks.

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following? (check all that apply)

- ❑ Diabetes (type)_______________
- ❑ Thyroid Disease
- ❑ Cancer (type)________________
- ❑ GERD
- ❑ Gallbladder Disease
- ❑ Crohn's Disease
- ❑ Colitis
- ❑ Liver Disease
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Fibromyalgia
- ❑ Pneumonia
- ❑ Heart Attack
- ❑ Stroke
- ❑ Aneurysm
- ❑ Heart Disease
- ❑ Angina (Chest Pain)
- ❑ Hypertension
- ❑ Blood Clots/DVT
- ❑ Epilepsy/Seizures
- ❑ Scoliosis
- ❑ Herniated Disc or Sciatica
- ❑ Migraine Headache
- ❑ Cluster Headache
- ❑ Rheumatoid Arthritis
- ❑ Osteoarthritis
- ❑ Gout
- ❑ Osteoporosis
- ❑ Other________________________
- ❑ Other________________________

Previous surgeries and year ____

SOCIAL HISTORY

Occupation ____ Employer ____________________________

If student, list areas of study ____________________________ Year in school _________________________

Alcohol Use ❑ None ❑ Occasionally ❑ Frequently Tobacco Use ❑ None ❑ Occasionally ❑ Frequently

Do you exercise regularly? ❑ No ❑ Yes (type and how often) ____

MEDICATIONS AND SUPPLEMENTS

Please list any current medications and/or supplements ____

____

Are there any other concerns you would like us to be aware of?____

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