

**Askeland Chiropractic & Acupuncture P.C.**

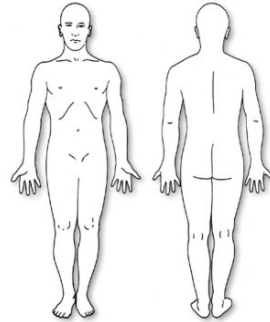
**PATIENT HISTORY**

Date \_\_\_\_\_  
NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE (H) \_\_\_\_\_ PHONE (W) \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
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?**

- |                                       |  |   |
|---------------------------------------|--|---|
| <input type="checkbox"/> HEADACHES    | <input type="checkbox"/> MEMORY LOSS         | <input type="checkbox"/> NUMB HANDS OR FEET     |
| <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> RINGING IN THE EARS | <input type="checkbox"/> COLD HANDS OR FEET     |
| <input type="checkbox"/> CHEST PAIN   | <input type="checkbox"/> DIGESTIVE PROBLEMS  | <input type="checkbox"/> SHOTNESS OF BREATH     |
| <input type="checkbox"/> DEPRESSION   | <input type="checkbox"/> LIGHT SENSITIVITY   | <input type="checkbox"/> DIFFICULTY SLEEPING    |
| <input type="checkbox"/> DIZZINESS    | <input type="checkbox"/> STRESS OR ANXIETY   | <input type="checkbox"/> LOSS OF SMELL OR TASTE |

*How will you be paying for your 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 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 those that apply)

- \_\_\_ Fractured Bones
- \_\_\_ Auto Accidents
  - \_\_\_ 0-1 yrs
  - \_\_\_ 1-5 yrs
  - \_\_\_ 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 hands, fingers R L
- \_\_\_ Jaw pain or clicks (TIMJD)
  - \_\_\_ R L
- \_\_\_ Difficulty in excessive standing, sitting, riding, bending, lifting, twisting
- \_\_\_ Shoulder pain
- \_\_\_ Dizziness
- \_\_\_ Ringing in ears
- \_\_\_ Hearing Loss
- \_\_\_ Blurred or doubled vision
- \_\_\_ Upper 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 (NOW)
  
- \_\_\_ Bed wetting
- \_\_\_ AIDS, HIV