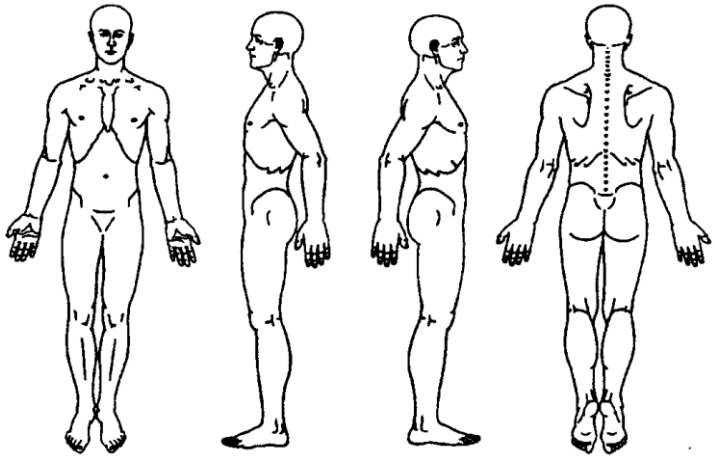
Carthage Family Chiropractic, LLC
615-735-9336

Date: _____/_____/_____ Patient's Full Name: _____ DOB: _____/_____/_____

Mark Your Pains / Problems On The Picture



In Order of Importance, List Your Pains / Problems

Complaint #1: _____

Onset Date: _____

Severity: 0 1 2 3 4 5 6 7 8 9 10

No pain Unbearable Pain

Complaint #2: _____

Onset Date: _____

Severity: 0 1 2 3 4 5 6 7 8 9 10

No pain Unbearable Pain

How did complaint #1 start? (ex. Fell on ice): _____

What makes it worse? [ ] Bending [ ] Standing [ ] Sitting [ ] Walking Other: _____

What makes it better? [ ] Laying down [ ] Sitting [ ] Standing [ ] Walking Other: _____

What does the pain feel like? [ ] Sharp [ ] Dull/Ache [ ] Throbbing [ ] Tingly/Numb/Burn Other: _____

When does it bother you the most? [ ] Morning [ ] During day [ ] Evening [ ] Lying in bed Other: _____

What percentage of the day do you experience it? [ ] 0-25% [ ] 25-50% [ ] 50-75% [ ] 75-100%

Have you ever experienced complaint #1 before? [ ] Yes [ ] No If yes, when? _____

- Was treatment provided? [ ] Yes [ ] No If yes, by whom? _____ Outcome: _____

Have your pains resulted in any: [ ] Muscle weakness [ ] Bowel/Bladder Control [ ] Digestion Issues [ ] Heart/Breathing Issues

Have you tried ice, heat, stretches, or taken any medication (over the counter or prescribed) for your current pain? [ ] Yes [ ] No

- If yes, explain:_____ Results:_____

What is your goal from treatment (ex. Play a round of golf without pain)? _____

Have you ever had a stroke or issues with blood clotting? [ ] Yes [ ] No If yes, when: _____

Have you recently experienced dizziness, unexplained fatigue, weight loss, or blood loss? [ ] Yes [ ] No

- If yes, explain: _____ Are you currently taking an anticoagulant or blood thinner? [ ] Yes [ ] No

Date	Major Injury/Fracture/Illness/Surgeries	Treatment	Results

****Please complete the back side of this form****

Please list any allergies: _____

Please list any supplements or medications you currently take: _____

_____

[ ] Yes [ ] No Do you exercise? Times per week: _____

[ ] Yes [ ] No Use tobacco? Type: _____ Packs/cans per day: _____ If you quit, when did you quit? _____

[ ] Yes [ ] No Consume alcohol? How many drinks per week? _____

[ ] Yes [ ] No Healthy diet? If no, explain: _____

[ ] Yes [ ] No Get adequate sleep? If no, explain: _____

[ ] Yes [ ] No Is work/school stressful to you? If yes, explain: _____

[ ] Yes [ ] No Family life stressful to you? If yes, explain: _____

[ ] Yes [ ] No Use recreational drugs? If yes, explain: _____

Family History and Health Status (list ay hereditary diseases or major illnesses which affect your mother/father/sister/brother):

Mother: _____

Father: _____

Siblings: _____

Females: Date of last gynecological and breast exam: _____ Possible pregnancy? [ ] Yes [ ] No

Date of last menstrual cycle: _____

I hereby state that all information I have provided is complete and truthful, and that I have fully disclosed my health history.

Signature: _____ Date: _____/_____/_____