RUFF CHIROPRACTIC

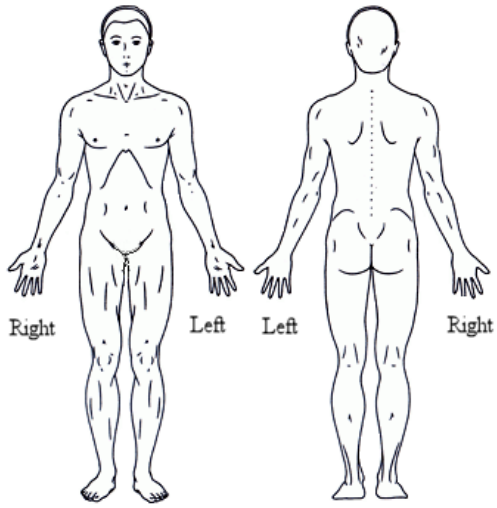
Confidential Information

PERSONAL INFORMATION:

Name _____Age _____Date _____
Address _____ City _____ State_____ Zip_____
Email _____ Primary Phone_____
Date of Birth _____ Sex: M F Marital Status: S M D W
Occupation _____Phone _____
Emergency Contact _____ Phone_____
How did you hear about us?_____

CHIEF COMPLAINT:

Reason for seeking care: _____
When/ how did it start?_____
List any other doctors seen for this: _____
List any diagnosis and type of treatment: _____
Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____
Any relatives that have or have had a similar problem: _____



Please circle degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10
How would you describe the pain?

- Numb
- Dull Ache
- Burning
- Sharp/Stabbing
- Pins, Needles
- Other _____

What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day? Y/N
Is this condition interfering with Work?_____
Sleep?_____Routine?_____Other?_____
Is this condition progressively getting worse?_____
_____

Have you been treated for any health condition by a physician in the last year? __ Yes __ No
If yes, explain: _____
Are you currently taking medication? __ Yes __ No list medications: _____
_____
Have you taken medication in the past year? __ Yes __ No list medications _____
List conditions you are taking medications for: _____
Previous surgeries or injuries & dates:_____
_____
Family History of high blood pressure, high cholesterol, diabetes, osteoporosis, arthritis, heart disease?
If yes, who and what:_____

Do you smoke Y/N ____ •Alcohol Y/N __Daily __Weekly __Social Occasions •Caffeinated drinks per day ____
Do you take Vitamins/Supplements Y/N If yes, type and how often _____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.
Patient
Signature_____Date_____