

Have you seen another doctor for this condition? Yes No Doctor's Name: _____

Date Consulted: _____ Diagnosis: _____

Does this condition interfere with your sleep? Yes No If so, how many times do you wake up in pain per night? _____

In what position do you sleep? Back Side Stomach

Do you sleep with a pillow? Yes No How Many? _____

Does heat affect the pain? Yes No If so, how? _____

Does cold affect the pain? Yes No If so, how? _____

Do you wear a heel lift? Yes No If so, which side? Right Left

Does it cause pain to cough, grunt, or sneeze? Yes No If so, where? _____

PATIENT HISTORY

Have you ever had any surgeries or hospitalizations? Yes No Please List:

Type of Hospitalization/Surgery:	Date:	Type of Hospitalization/Surgery:	Date:

Have you been x-rayed or received MRI, CAT scan in the last 12-18 months? Yes No When? _____

Have you ever been seen by a chiropractor before? Yes No Please List:

Chiropractor:	Dates:	Chiropractor:	Dates:

Do you have a family physician? Yes No Name of Physician: _____ Phone: _____

Address: _____ City, State, Zip: _____

If female, are you pregnant? Yes No If no or not sure, date of your last menstrual period: _____

AREAS OF INTEREST

Please mark areas of interest or if you desire more information:

- | | | |
|--|--|--|
| <input type="checkbox"/> Nutritional Supplements | <input type="checkbox"/> Neck/Body Pillows | <input type="checkbox"/> Ear Infections/colic, ADD |
| <input type="checkbox"/> Detoxification | <input type="checkbox"/> Decompression | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Others (list) |
| <input type="checkbox"/> Weight Loss Information | <input type="checkbox"/> Wellness Care | _____ |
| <input type="checkbox"/> Women's Health | <input type="checkbox"/> Children's Care | _____ |