RC Chiropractic, LLC
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Today's Date:_____
Name: _____ Birth Date:_____ Age: _____ Height:_____
Weight:_____lbs Address:_____ City:_____
State:_____ Zip Code:_____ Phone Number:_____
Cell:_____ Email:_____
May we thank who referred you-
_____
○ Sign ○ Internet ○ Yellow Pages ○ Hotel

Who is your Primary Medical Doctor/Health Care Provider?
_____

Please list your problem(s) Rate your pain(circle least & worst)

1)_____ 0 1 2 3 4 5 6 7 8 9 10
My pain is → ○Dull, ○Achy ○Numb ○Sharp ○Shooting ○Spasm ○Burning ○ Tingling ○Throbbing ○Weakness ○ Other
I Feel It → ○ **Constantly**(>76% of day) ○**Frequently** (51-75%) ○**Occasionally** (25-50%) ○**Intermittently** (<25%) of the time.

2)_____ 0 1 2 3 4 5 6 7 8 9 10
My pain is → ○Dull, ○Achy ○Numb ○Sharp ○Shooting ○Spasm ○Burning ○ Tingling ○Throbbing ○Weakness ○ Other
I Feel It → ○ **Constantly**(>76% of day) ○**Frequently** (51-75%) ○**Occasionally** (25-50%) ○**Intermittently** (<25%) of the time.

When did this begin? _____
_____

What Caused it?_____
_____

Have you ever had this before? ○ No (First Time) ○ Yes, ○Once before, ○Several times, ○ Meany Times ○ Other:
_____

It is getting: ○ Better ○Same ○Worst ○ Other: _____

Dose the pain **RADIATE**.
○ No/ ○Yes, to my ○Head ○ Shoulder ○ Arm ○ Buttock ○ Thigh ○Leg ○ Foot ○ Other: _____

What makes it feel better? ○ Nothing/○ Sitting ○ Standing ○ Walking ○ Movement ○ Ice ○ Heat ○ Exercise ○ Massage
○ Drugs(List)_____ ○ Other_____

What makes it Worse? ○ Lying down ○ Sitting ○ Standing ○ Walking ○ Movement ○ Ice ○ Heat ○ Exercise
○Other (Explain) _____
Have you had any treatment for this current problem? ○Yes/○No→ ○ Medical, ○Chiropractic ○ Physical Therapy ○ Massage
○Acupuncture ○ Ice ○Heat ○ Drugs_____ Did it help? ○ Yes/ ○ No

Past Health History

Have you ever been seen by a Chiropractic care before? ○No/○Yes → ○ Same Problem, Different Problem (Explain)

When was your last adjustment #___ (○ Days, ○ Weeks, ○ Month, ○ Years) Dr.?_____

Your occupation/ Type work activity:_____
Work activity: ○ Office Work #_____ Hours Sitting per day? ○Physical Work → ○ Light ○ Moderate ○ Heavy

Is this problem affecting your ability to work, play exercise, or perform your normal activities of daily living?
○ No/ ○ Yes → ○ I can do with mild annoyance, ○ I can do, it but it hurts, ○ I cannot do it (too much pain)
○ Other (explain) _____

Any SIGNIFICANT Past Injuries/ Accidents/ Falls? ○ No/○Yes (explain)
_____

Surgery? ○No/○Yes (explain)?

_____
_____

Current Medication? ○ No/ ○Yes (Explain)
_____

Recent X-Ray, MRI, CT Scans or other Diagnostic Studies? ○ No/ ○ Yes (explain)
_____

Please Check all that apply: (C = Current, P= Past)

C / P
○ /○ Adrenal Fatigue
○ /○ Insomnia
○ /○ Headaches
○ /○ Thyroid : ○ Hypo ○Hyper
○ /○ Goiter
○ /○ Depression
○ /○ Fibromyalgia
○ /○ Allergy Shots
○ /○ Anemia
○ /○ Bronchitis
○ /○ Asthma/ Emphysema
○ /○ Pneumonia
○ /○ Breast Lumps
○ /○ Cancer _____
○ /○ Cataracts/ Glaucoma
○ /○ Pinched Nerve
○ /○ Herniated Disk
○ /○ Heart Disease
○ /○ High Cholesterol
○ /○ High Blood Sugar

C / P
○ /○ High Blood Pressure
○ /○ High Triglycerides
○ /○ Coronary Arteries Disease
○ /○ Atherosclerosis
○ /○ Pacemaker
○ /○ Stroke
○ /○ Hypoglycemia
○ /○ Insulin Resistance
○ /○ Diabetes Type _____
○ /○ Central Obesity
○ /○ Metabolic Synod/ Syndrome X
○ /○ IBS (Irritable Bowel Syndrome)
○ /○ Crohn's Disease
○ /○ Kidneys Disease/ Stones
○ /○ Liver Disease
○ /○ Gallbladder Disease/ Stones
○ /○ Multiple Sclerosis
○ /○ HIV/AIDs
○ /○ Limes Disease
○ /○ Herpes

C / P
○ /○ Chickenpox
○ /○ Hepatitis _____
○ /○ Mumps
○ /○ Measles
○ /○ Osteoarthritis
○ /○ Rheumatoid Arthritis
○ /○ Gout
○ /○ Osteoporosis
○ /○ Parkinson's Disease
○ /○ PCOS
○ /○ Rheumatic Fever
○ /○ Scarlet Fever
○ /○ Tuberculosis (TB)
○ /○ Ulcers
○ /○
○ /○ Gallbladder Disease/ Stones
○ /○ Multiple Sclerosis
○ /○ HIV/AIDs
○ /○ Limes Disease
○ /○ Herpes

Any other Health Problems? ○ No / ○ Yes (explain)
_____
Significant Family History or illness? ○ No / ○ Yes (explain) _____

Patient/Parent/ Guardian Signature _____Date ___