

# Quest Chiropractic Center

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ CellPhone \_\_\_\_\_ WorkPhone \_\_\_\_\_  
Email address \_\_\_\_\_ Sex M/F Age \_\_\_\_\_  
DOB \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status/ S M D W  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Work Address \_\_\_\_\_  
If applicable:  
Parents/Legal Guardians Name \_\_\_\_\_  
Address \_\_\_\_\_  
Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
No. of Children \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_

## Main Complaint

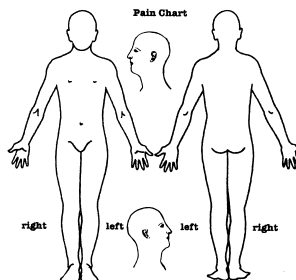
1. What is your major symptom? \_\_\_\_\_
  2. What does this prevent you from doing or enjoying? \_\_\_\_\_  
\_\_\_\_\_
  3. What is your treatment goal? \_\_\_\_\_
  4. If this is a recurrence, when was the first time you noticed the problem? \_\_\_\_\_
  5. How did it originally occur? \_\_\_\_\_
  6. Has it become worse recently? Yes \_\_\_\_\_ No \_\_\_\_\_ Same \_\_\_\_\_ Gradually Worse \_\_\_\_\_  
If yes, when and how? \_\_\_\_\_
  7. How frequent is the condition? Constant \_\_\_\_\_ Daily \_\_\_\_\_ Intermittent \_\_\_\_\_ Night Only \_\_\_\_\_
  8. How long does it last? All Day \_\_\_\_\_ Few Hours \_\_\_\_\_ Minutes \_\_\_\_\_
  9. How many days have you lost from work due to these symptoms? \_\_\_\_\_
  10. Are there any other conditions or symptoms that may be related to your major symptoms Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, describe \_\_\_\_\_  
\_\_\_\_\_
  11. Are there other unrelated health problems? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, describe \_\_\_\_\_  
Describe the pain: Sharp \_\_\_\_\_ Dull \_\_\_\_\_ Numbness \_\_\_\_\_ Tingling \_\_\_\_\_ Aching \_\_\_\_\_ Burning \_\_\_\_\_ Stabbing \_\_\_\_\_  
Other \_\_\_\_\_
  12. Is there any thing you can do the relieve the problem? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, describe \_\_\_\_\_  
\_\_\_\_\_. If no, what have you tried to do that has not helped? \_\_\_\_\_
  13. What makes the problem worse? Standing \_\_\_\_\_ Sitting \_\_\_\_\_ Lying \_\_\_\_\_ Bending \_\_\_\_\_ Lifting \_\_\_\_\_ Twisting \_\_\_\_\_ Other \_\_\_\_\_
  14. Have you had any broken bones? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, please list and give dates \_\_\_\_\_
  15. List any major accidents you have had other than those that might be mentioned above: \_\_\_\_\_
  16. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? \_\_\_\_\_
  17. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ Uncertain \_\_\_\_\_
- Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

No Pain

Unbearable Pain

Please place an "X" on the line above to indicate level of problem.

Show area(s) of pain or  
unusual feeling,  
pain or discomfort.



## Past History

Past Chiropractic care / doctor's name \_\_\_\_\_  
Family physician \_\_\_\_\_ Medications \_\_\_\_\_  
Surgeries / dates \_\_\_\_\_  
Illness / abnormalities \_\_\_\_\_  
Previous Injuries & accidents / dates \_\_\_\_\_

## Do you have difficulty with any of the following?

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Fainting                     | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Bladder Trouble         |
| <input type="checkbox"/> Shooting head pains    | <input type="checkbox"/> Loss of balance              | <input type="checkbox"/> Low blood pressure   | <input type="checkbox"/> Menstrual cramps & pain |
| <input type="checkbox"/> Sinus Trouble          | <input type="checkbox"/> Ringing in ears              | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Menstrual Irregularity  |
| <input type="checkbox"/> Loss of smell          | <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> Hayfever               | <input type="checkbox"/> Light bothers eye            | <input type="checkbox"/> Nervous stomach      | <input type="checkbox"/> Cancer                  |
| <input type="checkbox"/> Asthma/allergies       | <input type="checkbox"/> Muscle spasms in neck        | <input type="checkbox"/> Stomach trouble      | <input type="checkbox"/> Sleeping problems       |
| <input type="checkbox"/> Loss of taste          | <input type="checkbox"/> Grating in neck              | <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Painful joints          |
| <input type="checkbox"/> Tightness in throat    | <input type="checkbox"/> Tightness of shoulder muscle | <input type="checkbox"/> Nerves & nervousness | <input type="checkbox"/> Swollen joints          |
| <input type="checkbox"/> Inflammation of throat | <input type="checkbox"/> Neuritis in shoulders & arms | <input type="checkbox"/> Inner tension        | <input type="checkbox"/> Arthritis               |
| <input type="checkbox"/> Thyroid Trouble        | <input type="checkbox"/> Pins & needles in hands      | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Slipped disk            |
| <input type="checkbox"/> Face flushed           | <input type="checkbox"/> Cold hands                   | <input type="checkbox"/> Cold sweats          | <input type="checkbox"/> Pinched nerves in back  |
| <input type="checkbox"/> Twitching of face      | <input type="checkbox"/> Chest pains                  | <input type="checkbox"/> Liver trouble        | <input type="checkbox"/> Pins & needles in legs  |
| <input type="checkbox"/> Loss of memory         | <input type="checkbox"/> Shortness of breath          | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Swollen ankles          |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Heart attacks                | <input type="checkbox"/> Indigestion          | <input type="checkbox"/> Cold feet               |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Heart pain                   | <input type="checkbox"/> Intestinal gas       | <input type="checkbox"/> Pains in legs & feet    |
| <input type="checkbox"/> Head feels too heavy   | <input type="checkbox"/> Heart palpation              | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Kidney trouble          |
| <input type="checkbox"/> Weight gain            | <input type="checkbox"/> Weight loss                  |   |  |

## Family Medical History

Breast cancer	Other cancers	Cardiovascular disease	Stroke
Osteoporosis	Alcoholism	Mental illness/Depression	Obesity
Alzheimer's	Diabetes	Arthritis	Allergies

Please place an "F" for father or father's side or "M" for mother's side of the family in front of anything you circled in this section above.

## Lifestyle and Diet

Rate your current level of stress on a scale of 1 to 10 (1=low): 1 2 3 4 5 6 7 8 9 10

What are the major causes? Work Family Finances Relationships Emotions  
Other \_\_\_\_\_

I eat the following: Sweets Cereals Sodas/Pop Legumes Ice cream Fruits Fried foods Vegetables

List your 4 favorite foods: \_\_\_\_\_

This applies to me: Diet frequently Skip meals Dine out regularly

Eat ( 0 1 2 3 4 5 6 more) meals a day

When do you eat? Morning, Noon, Night, Constantly snacking

Do you:  
-use tobacco? YES or NO If yes, how much daily? \_\_\_\_\_  
If no, did you ever? YES or NO if yes how long? \_\_\_\_\_

-Are you exposed to second hand smoke YES or NO If yes, how much daily? \_\_\_\_\_  
If no, did you ever? YES or NO if yes how much? \_\_\_\_\_

-drink coffee? YES or NO If yes, how much daily? \_\_\_\_\_  
If no, did you ever? YES or NO if yes how much? \_\_\_\_\_  
Is it - strong mild decaf?

-eat chocolate? YES or NO If yes, how much daily? \_\_\_\_\_

-drink alcohol? YES or NO If yes, how many ounces a day/ week? \_\_\_\_\_  
If no, did you ever? YES or NO if yes how much? \_\_\_\_\_  
How long did you drink before you stopped? \_\_\_\_\_

-restrict your intake or avoid completely:  
Fiber Dairy products Salt Animals protein Sugar All animal foods Fat

## Exercise

Exercise weekly? YES or NO If yes, how many times per week? \_\_\_\_\_

I agree that the information I provided is correct \_\_\_\_\_