

1458 E. Chicago Ave. Naperville, IL. 60540

(630) 357-0100 Office (630) 357-0102 Fax

www.nhchirowellness.com

Name:	Todays Date:
Address:	
City:	State: Zip:
Home Phone: Cell Phone:	Work Phone:
Preferred Method of Contactemail:	Ok to text? Yes No Cell Carrier:
Social Security #:	Birth Date: Age:
Emergency Contact: Yes  \text{No} \text{ Date}	Single Married Widowed Divorced Phone: Relationship: Of last LMP:
Occupation: Employers Address:	oyers Name:
How did you hear of our office? (Please List):	e Company: Other (describe on lines below)
Problem(s) are (check one): Constant Fro Indicate on the drawings below where you have pain/syr If multiple areas, please number them.	equent Occasional Intermittent  mptoms: How would you describe the type of pain?
	Sharp Numb  Dull Tingly  Diffuse Sharp with motion  Achy Shooting with motion  Burning Stabbing with motion  Shooting Electric with motion  Stiff Other (describe below)  Throbbing

Name: Todays Date:
How are your symptoms changing with time: Getting worse Staying the same Getting better
Using a scale of 0-10 (10 being the worst), how would you rate your problem(s)? Please choose a number for each problem.  0 1 2 3 4 5 6 7 8 9 10
Has the problem interfered with work:
Not at all Slightly Moderately Quite a bit Extremely
Has the problem interfered with personal/family life (socially, hobbies, etc):
Not at all Slightly Moderately Quite a bit Extremely
Others you have seen for Chiropractor Neurologist Primary Care Physician
this/these problem(s):  ER Physician  Orthopedist  No One
Massage Therapist Physical Therapist Other
How long have you had this/these problem(s): How did it begin:
Do you consider this/these problem(s) to be severe: Yes Yes, at times No  What aggravates your problem(s):
What alleviates your problem(s):
What concerns you most about your problem(s):
What is your: Height: Weight:
How would you rate your overall health:
Excellent Very Good Good Pair Poor
What kind of exercise do you do:
Strenuous Moderate Light None Describe:
Do any immediate family members have any of the following:
Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus ALS
Stroke Other If yes, who:

Name	::		1	Гodays	Date:	
For ea	Present  Headaches  Neck Pain  Upper Back Pain  Mid Back Pain  Low Back Pain  Shoulder Pain  Elbow/Upper Arm Pain  Wrist Pain		heck in the "past" column if yo heck in the "present" column. Thyroid Condition Asthma High Blood Pressure Heart Attack Chest Pains Stroke Angina Kidney Stones	,		Liver/Gall Bladder Disorder General Fatigue Muscular Incoordination Visual Disturbances Diabetes Excessive Thirst Frequent Urination Smoking/Tobacco Use
Briefly	Hand Pain Hip Pain Upper Leg Pain Knee Pain Ankle/Foot Pain Jaw Pain Joint Pain/Stiffness Arthritis Rheumatoid Arthritis Cancer Tumor r explain any checked condition	s "past" or "	Kidney Disorders Bladder Infection Painful Urination Loss of Bladder Control Prostate Problems Abnormal Weight Gain/Loss Loss of Appetite Abdominal Pain Ulcer Hepatitis Digestive Issues present" from above:			Drug/Alcohol Dependence Allergies Depression Systemic Lupus Epilepsy Dermatitis/Eczema/Rash HIV/AIDS Birth Control Pills (Female) Hormonal Replacement (Female) Pregnancy (Female) Diarrhea/Constipation
What prescription/over the counter medications you are currently taking and why:						
List any medical procedures/tests/bloodwork done in the last 5 years:						

Name:	Todays Date:					
	asis (choose as many as you do, and then check the amount for each):					
$\bigcup_{i \in I} Sit \longrightarrow$	Most of the day  Half of the day  A little of the day					
$\bigcup_{i \in \mathcal{S}} Stand \longrightarrow$	Most of the day  Half of the day  A little of the day					
Computer Work ————	Most of the day  Half of the day  A little of the day					
On the Phone ————	Most of the day  Half of the day  A little of the day					
Drive ————	Most of the day Half of the day A little of the day					
Bending/Lifting ————	Most of the day Half of the day A little of the day					
What activities do you do outside of v	vork (please list):					
Have you ever had significant trauma	(falls, car accidents, injuries, etc): No Yes (when & explain):					
Is there any other information the do	ctor should be aware of:					
Are there any questions/concerns you	u may have for the doctor:					
Have you ever seen a Chiropractor be	fore: No Yes (when & explain):					
How would you describe your results	(if answering yes above): Great Good Fair Mixed Poor					
Signature:	Date:					