Fenander

Chiropractic & Wellness

Name: _____
Last Name First Middle

Address: _____ City:_____

State: _____ Zip Code: _____ Birthdate: _____ Age: _____

Phone: _____ Cell: _____ Sex:_____

Marital Status:
- Married
- Divorced
- Minor
- Widowed
- Single

Email: _____ Occupation: _____

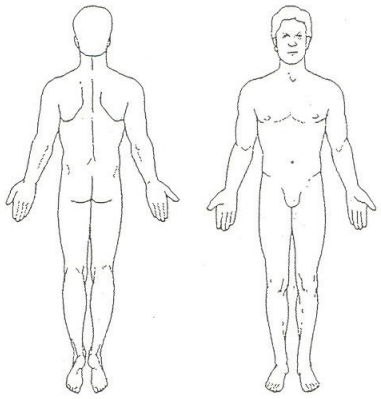
Employer: _____ Work Phone: _____

IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

1. **Location** *(Where does it hurt?)* Circle the area(s) on the illustration



2. **Symptoms**
   - ☐ Numbness
   - ☐ Tingling
   - ☐ Stiffness
   - ☐ Dull
   - ☐ Aching
   - ☐ Cramps
   - ☐ Sharp
   - ☐ Shooting
   - ☐ Throbbing
   - ☐ Stabbing
   - ☐ Other

3. **Intensity** *(What does it feel like?)* O—O—O—O—O—O—O—O—O—O—O
   1 2 3 4 5 6 7 8 9 10
   Absent Uncomfortable Agonizing

4. **Onset:** When did it start?_____ How often do you feel it? **Constant** **Comes & goes**

5. **Radiation** *(Does it affect other areas of your body? And what areas does the pain radiate, shoot or travel?)*

_____

6. **Aggravating factors** *(What makes it worse, such as time of day, movements certain activities, etc).*

_____

7. **Relieving factors** *(What makes it better?)*

_____

8. **Is this injury the result of an Auto or Workplace Accident?** **Yes** **No**

HEALTH HISTORY

What treatment have you already received for your condition? ☐Medications ☐Surgery ☐Physical Therapy
☐Chiropractic Services ☐None ☐Other_____

Name and Address of other Doctor(s) who have treated you for your condition:
_____

Date of Last: Physical Exam _____ Spinal X-ray _____ Blood Test _____
Spinal Exam _____ Chest X-ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Please check all of the health conditions below that apply to you currently or in the past:

□ AIDS/HIV	□ Emphysema	□ Miscarriage	□ Suicide Attempt
□ Alcoholism	□ Epilepsy	□ Mononucleosis	□ Thyroid Problems
□ Allergy Shots	□ Fractures	□ Multiple Sclerosis	□ Tonsillitis
□ Anemia	□ Glaucoma	□ Mumps	□ Tuberculosis
□ Anorexia	□ Goiter	□ Osteoporosis	□ Tumors, Growths
□ Appendicitis	□ Gonorrhea	□ Pacemaker	□ Typhoid Fever
□ Arthritis	□ Gout	□ Parkinson's Disease	□ Ulcers
□ Asthma	□ Heart Disease	□ Pinched Nerve	□ Vaginal Infections
□ Bleeding Disorders	□ Hepatitis	□ Pneumonia	□ Venereal Disease
□ Breast Lump	□ Hernia	□ Polio	□ Whooping Cough
□ Bronchitis	□ Herniated Disk	□ Prostate Problem	□ Other _____
□ Bulimia	□ Herpes	□ Prosthesis	_____
□ Cancer	□ High Cholesterol	□ Psychiatric Care	
□ Cataracts	□ Kidney Disease	□ Rheumatoid Arthritis	
□ Chemical Dependency	□ Liver Disease	□ Rheumatic Fever	
□ Chicken Pox	□ Measles	□ Scarlet Fever	
□ Diabetes	□ Migraine Headaches	□ Stroke	

EXERCISE	**WORK ACTIVITY**	**HABITS**	
□ None	□ Sitting	□ Smoking	Packs/Day _____
□ Moderate	□ Standing	□ Alcohol	Drinks/Week _____
□ Daily	□ Light Labor	□ Coffee/Caffeine Drinks	Cups/Day _____
□ Heavy	□ Heavy Labor	□ High Stress Level	Reason _____

Are you pregnant? □ Yes □ No Due Date _____

Injuries/Surgeries you have had: Description Date

Falls _____ _____
Head Injuries _____ _____
Broken Bones _____ _____
Dislocations _____ _____
Surgeries _____ _____

MEDICATIONS:

_____
_____

ALLERGIES:

_____
_____

VITAMINS/HERBS/MINERALS:

_____
_____