PARADISE VALLEY
FAMILY CARE

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Reason for Visit

Reason for today's visit: [ ] Emergency [ ] New Injury [ ]Old Injury [ ] Chronic Pain [ ] Wellness
Are you in pain: [ ] Yes [ ] No Rate your pain with the following scale **discomfort 1 2 3 4 5 6 7 8 9 10 intense**

Did your injury occur during: [ ] Work [ ] Sports/Play [ ] Auto Accident [ ] Routine/Household Activity
When did your condition/accident occur? ____/____/____

Where did your injury occur?________________________________ Please explain what happened: ______________________________

____

Is your condition getting worse? [ ] Yes [ ] No [ ] Constant [ ] Comes and goes
Is your condition interfering with your: [ ] Work [ ] Sleep or [ ] Daily Routine? If so, how ______________________________

____

Has this or something similar happened in the past?
[ ] Yes [ ] No Explain: _______________________

____

____

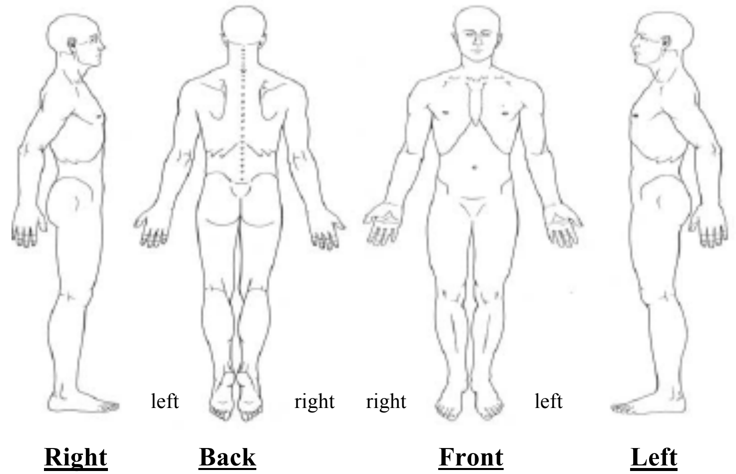
Using the adjacent body charts, please circle all affected areas.

Have you ever been treated by a Medical Physician for this condition? [ ] Yes [ ] No If so where? _______

____

Have you ever been treated by a Chiropractor?
[ ]Yes [ ] No
Clinic or Dr's Name: _____________________________

Clinic phone #: __________________________________



Health History

Are you taking any of the following medications? [ ] Nerve Pills [ ] Pain Killers (including aspirin) [ ] Muscle Relaxers
[ ] Blood Thinners [ ] Tranquilizers [ ] Insulin [ ] Other (s) ____

Do you have or have you had any of the following diseases, medical conditions or procedure

Y N Heart Attack/Stroke	**Y N** Heart Surg/Pacemaker	**Y N** Heart Murmur	**Y N** Cong Heart Defect	**Y N** Mitral Valve Prolapse
Y N Artificial Valves	**Y N** Alcohol/Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis	**Y N** HIV+ / AIDS / ARC
Y N Shingles	**Y N** Cancer	**Y N** Freq Neck Pain	**Y N** Glaucoma	**Y N** Anemia / Diabetes
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever	**Y N** Severe/Freq Headaches	**Y N** Kidney Problems
Y N Ulcers/Colitis	**Y N** Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Emphysema/Asthma	**Y N** Tuberculosis
Y N Difficulty Breathing	**Y N** Chemotherapy	**Y N** Lower Back Problems	**Y N** Art.Bones/Joints/Implants	**Y N** Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: ______________________________

____

List any past serious accidents with dates: ____

Please list anything you may be allergic to: ____

Family Health History: ____

Do you take Supplements or Vitamins? [ ] Yes [ ] No Do you exercise? [ ] No [ ] Yes _____ hours per week

Do you smoke? [ ] No [ ] Yes How Much? ________________ How long? ____________________

Are you wearing: [ ] Shoe Lifts [ ] Inner Soles [ ] Arch Supports Are you dieting: [ ] No [ ] Yes Since: ____/____/____

For Women: Are you taking birth control? [ ] Yes [ ] No
Are you Nursing? [ ] Yes [ ] No Are you pregnant? [ ] No [ ] Yes If so, how many weeks? ________________

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature: ____ Date: _____________