WOODLANDS FAMILY CHIROPRACTIC
128 Vision Park Blvd, Suite 250
The Woodlands, Texas, 77384
Ph 936.447.9484
Fx 936.447.9497

Patient Name: ____________________________

Date Of Birth: ____________________________

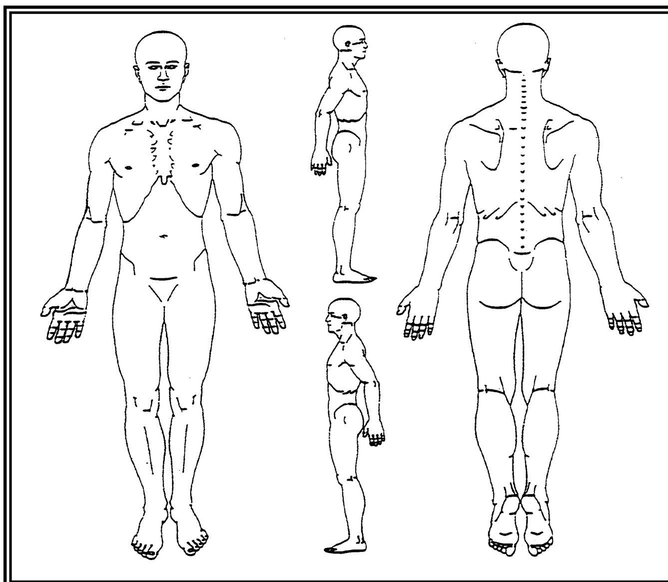
Date Of Exam: ____________________________

We appreciate you choosing our office. Is there anyone we can thank for referring you? ____________________________

Please indicate the main reason you are seeing us today: ____________________________

IF you are seeing us for a PAIN related issue, USE THE SYMBOLS to show the type of pain you feel in each location.

XXXXXXXXX	/ / / / / / / / / /	o o o o o o o o o o	s s s s s	- - - - - - - -
DULL/ACHY	**SHARP/STABBING**	**NUMBNESS/TINGLING**	**STIFF/TIGHT**	**BURNING**



Using the PAIN SCALE below, CIRCLE the pain level you experience when your problem is at its WORST:

0 = No Pain. No Discomfort
1 = Minimal Discomfort. Minor stiffness or tightness.
2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
3 = Minimal Pain. More than just sore. Uncomfortable.
4 = Mild Pain. Noticeable pain but tolerable.
5 = Moderate Pain. Aggravating. Still allows movement.
6 = Strong Pain. Quite aggravating. Movement slightly limited.
7 = Very Strong Pain. Very aggravating. Movement definitely limited.
8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
9 = Severe Pain. Brings tears. Almost impossible to move.
10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Is there any RADIATING PAIN into the arms or legs? _____________ **Any numbness or tingling?** ___________________

How OFTEN do you experience your problem? (Please indicate for EACH SEPARATE LOCATION if applicable)

Constant (75 – 100% of the time) ____________________________

Frequent (50 – 75% of the time) ____________________________

Occasional (25 – 50% of the time) ____________________________

Intermittent (0 – 25% of the time) ____________________________

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List any MD's or other CHIORPRACTORS you've already seen for this problem: ____________________________________

What TESTS have you already had for this problem? ôX-rays ôMRI ôC.T. Scan ôMyelogram ôEMG/NCV
ôNone ôOther ____

What REMEDIES have you already tried for this problem that haven't fixed it yet? ôAnti-inflammatory ôPain Meds
ôMuscle Relaxers ôInjections ôPhysical Therapy ôChiropractic ôMassage ôExercise ôOther __________________________

What makes your problem WORSE? ôSitting ôStanding ôChanging Position ôWalking ôBending ôLifting ôTwisting
ôReaching ôDriving ôSleeping ôSneeze/Cough ôComputer Work ôTelephone ôGoing From Sit To Stand
ôOther____

PAST MEDICAL HISTORY

Please list any conditions that you've been DIAGNOSED with or been treated for over the course of your life:

____

____

Please list any SURGERIES you have had over the course of your life: ____

____

MEDICATIONS & ALLERGIES

Are you ALLERGIC to any medications? ôYes ôNo **If yes, please list:** ____

List any MEDS, HERBS OR SUPPLEMENTS you are taking: ____

____

FAMILY HISTORY

Mother: ôLiving ôDeceased List any medical problems: ____

Father: ôLiving ôDeceased List any medical problems: ____

List any problems COMMON in your family: ôCancer ôDiabetes ôHeart disease ôHigh blood pressure ôStroke ôArthritis
ôScoliosis ôThyroid disease ôOsteoporosis ____

SOCIAL HISTORY

Marital status: ôMarried ôSingle ôDivorced ôCommon Law ôEngaged ôWidowed

Do you have any children? ôYes ôNo If yes, how many? ____

Do you drink alcohol? ôYes ôNo If yes, how much & how often? ____

Do you smoke? ôYes ôNo If yes, how much, how often & how long? ____

Do you use any illegal drugs? ôYes ôNo If yes, what drugs, how often & how long? __________________________________

Are you currently employed? ôYes ôNo If yes, what is your occupation? ____

Who is your current employer? ________________________ **How long have you been at this job?** ____________________

On a scale of 0 to 10 with 0=Worst and 10=Best, rate how well you think you are doing with the following:

Exercise_______ Sleep _______ Diet ________ Stress Level ______ Water Intake _______ Energy Level_________ = __________

Do you take: Omega 3 (Fish Oil)? Yes No Vitamin D3? Yes No Probiotics? Yes No

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REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days: 0 = Never have this symptom
1 = Occasionally have this symptom, effect not severe
2 = Occasionally have this symptom, effect is severe
3 = Frequently have this symptom, effect not severe
4 = Frequently have this symptom, effect is severe

Head: ______ Headaches ______ Faintness ______ Dizziness ______ Insomnia	**Energy/Activity:** _____ Fatigue/Sluggishness _____ Apapthy/Lethargy _____ Hyperactivity _____ Restlessness	**Lungs:** _____ Chest Congestion _____ Asthma, Bronchitis _____ Shortness Of Breath _____ Difficulty Breathing
Eyes: _____ Watery or Itchy Eyes _____ Swollen, Red or Sticky Eyelids _____ Bags or Dark Circles Under Eyes _____ Blurred or Tunnel Vision (not including near or far sightedness)	**Weight:** _____ Binge Eating/Drinking _____ Craving Certain Foods _____ Excessive Weight _____ Compulsive Eating _____ Water Retention _____ Underweight	**Heart:** _____ Irregular or Skipped Heartbeat _____ Rapid or Pounding Heartbeat _____ Chest Pain
Ears: _____ Itchy Ears _____ Earaches, Ear Infections _____ Drainage From Ear _____ Ringing In Ears, Hearing Loss	**Emotions:** _____ Mood Swings _____ Anxiety/Fear/Nervousness _____ Anger/Irritability/Aggressiveness _____ Depression	**Digestive Tract:** ______ Nausea, Vomiting ______ Diarrhea ______ Constipation ______ Bloated Feeling ______ Belching, Passing Gas ______ Heartburn ______ Intestinal/Stomach Pain
Nose: _____ Stuffy Nose _____ Sinus Problems _____ Hay Fever _____ Sneezing Attacks _____ Excessive Mucus Formation	**Mind:** _____ Poor Memory _____ Confusion, Poor Comprehension _____ Poor Concentration _____ Poor Physical Condition _____ Difficulty Making Decisions _____ Stuttering or Stammering _____ Slurred speech	
Mouth & Throat: _____ Chronic Coughing _____ Frequent Need to Clear Throat _____ Sore Throat, Hoarseness _____ Swollen or Discolored Tongue _____ Canker Sores		**Other:** ______ Frequent Illness ______ Frequent or Urgent Urination ______ Genital Itch or Discharge
Skin: _____ Acne _____ Hives, Rashes, Dry Skin _____ Hair Loss _____ Flushing, Hot Flashes _____ Excessive Sweating	**Joints/Muscles:** _____ Pain or Aches in Joints _____ Arthritis _____ Stiffness or Limited Movement _____ Pain or Aches in Muscles _____ Weakness or Fatigued Muscles	**Grand Total:**