

Name: _____ Date: ____/____/____

Please rate the following symptoms that you have experienced during the past 30 days.

0 = Never 1 = Occasional and Mild 2 = Occasional and Severe 3 = Often and Mild 4 = Often and Severe

- Head**
- 0 1 2 3 4 Headache
- 0 1 2 3 4 Faintness
- 0 1 2 3 4 Dizziness
- 0 1 2 3 4 Sleeplessness *
- Eyes, Ears, Nose, Throat**
- 0 1 2 3 4 Deafness
- 0 1 2 3 4 Sinus Trouble
- 0 1 2 3 4 Hay Fever
- 0 1 2 3 4 Sneezing
- 0 1 2 3 4 Nasal congestion/stuffy nose
- 0 1 2 3 4 Swollen Eyes
- 0 1 2 3 4 Reddened Eyes
- 0 1 2 3 4 Watery, Itchy Eyes
- 0 1 2 3 4 Dark Circles Under Eyes
- 0 1 2 3 4 Blurred Vision
- 0 1 2 3 4 Earache, Ear Infection
- 0 1 2 3 4 Ringing in the Ears
- 0 1 2 3 4 Coughing
- 0 1 2 3 4 Sore Throat
- 0 1 2 3 4 Hoarseness, Loss of Voice
- 0 1 2 3 4 Canker Sore
- 0 1 2 3 4 Discolored Lips or Gums *
- Memory, Emotions**
- 0 1 2 3 4 Mood Swings
- 0 1 2 3 4 Anxiety, Nervousness
- 0 1 2 3 4 Anger, Irritability
- 0 1 2 3 4 Aggressiveness
- 0 1 2 3 4 Depression
- 0 1 2 3 4 Poor Memory
- 0 1 2 3 4 Confusion
- 0 1 2 3 4 Lack of Concentration
- 0 1 2 3 4 Difficulty in Making Decisions
- 0 1 2 3 4 Stuttering
- 0 1 2 3 4 Slurred Speech
- 0 1 2 3 4 Learning Disabilities *
- Heart, Lungs**
- 0 1 2 3 4 Heart disease
- 0 1 2 3 4 High blood pressure
- 0 1 2 3 4 Low blood pressure
- 0 1 2 3 4 Slow heart beat
- 0 1 2 3 4 Hardening arteries
- 0 1 2 3 4 Irregular Heart Beat
- 0 1 2 3 4 Rapid, Pounding Heart Beat
- 0 1 2 3 4 Chest pain
- 0 1 2 3 4 Chest Congestion
- 0 1 2 3 4 Asthma
- 0 1 2 3 4 Bronchitis
- 0 1 2 3 4 Shortness of Breath *
- Genito-urinary**
- 0 1 2 3 4 Bed wetting
- 0 1 2 3 4 Frequent urination
- 0 1 2 3 4 Kidney infection/stone

- 0 1 2 3 4 Painful urination *
- Skin**
- 0 1 2 3 4 Acne
- 0 1 2 3 4 Dry, Scaly Skin
- 0 1 2 3 4 Hair Loss
- 0 1 2 3 4 Excessive Sweating
- 0 1 2 3 4 Oily Skin
- 0 1 2 3 4 Hot Flashes
- Digestion**
- 0 1 2 3 4 Nausea, Vomiting
- 0 1 2 3 4 Diarrhea
- 0 1 2 3 4 Constipation
- 0 1 2 3 4 Heartburn
- 0 1 2 3 4 Stomach Pain
- 0 1 2 3 4 Bloating
- 0 1 2 3 4 Belching, Gas *
- Joints**
- 0 1 2 3 4 Stiffness/Lack of Motion
- 0 1 2 3 4 Arthritis
- 0 1 2 3 4 Pain in the Muscles
- 0 1 2 3 4 Pain in the Joints *
- Energy Levels**
- 0 1 2 3 4 Weakness
- 0 1 2 3 4 Fatigue
- 0 1 2 3 4 Hyperactivity
- 0 1 2 3 4 Restlessness *†
- Weight**
- 0 1 2 3 4 Binge Eating/Drinking
- 0 1 2 3 4 Craving Certain Foods
- 0 1 2 3 4 Excessive Weight
- 0 1 2 3 4 Water Retention
- 0 1 2 3 4 Overweight
- 0 1 2 3 4 Underweight *

Diabetes Type 1	Prev	Now
Diabetes Type 2	Prev	Now
Cancer -- type:	Prev	Now
Prostate trouble	Prev	Now
Anemia	Prev	Now

FEMALES ONLY		
Pregnant	Yes	No
Number of children	_____	
Previous miscarriages	Yes	No
Painful menstruation	Yes	No
Irregular cycle	Yes	No
Date of last cycle	_____	
Excessive flow	Yes	No
Pre-Menopausal	Yes	No
Menopausal	Yes	No

Name _____ Date: _____ pg 2

Do you sleep on your: side back stomach? (Circle all that apply)

How many hours do you sleep? _____

Number of glasses of water a day: _____

Number of alcoholic beverages a week: _____

Number of cans of soda a day: _____

Number of cups of coffee or tea a day: _____

How many times do you eat fast food each week? _____

How many servings of fruits & vegetables are you eating a day? 0 1 2 3 4 5 6 7 8 9 10 (1 med. Fruit = 1 serving and 1 cup raw vegetables = 1 serving)

Number of cigarettes smoke a day: _____

Do you grind or clench your teeth? no yes

In an average day, how many hours do you sit? _____

Circle the average number of bowel movements do you have: (1-2 a day) (3-4 a day) (1-2 every 2-3 days) ((1-2 a week) other:

Circle your activities (what you do majority of day): sit stand light labor heavy labor

On a scale 1-10 what level of stress do you experience daily? (10 high) 1 2 3 4 5 6 7 8 9 10

Would you like to lose weight? yes no Do you engage in any cardiovascular exercise? yes no

If so, which activities? _____ How many days a week? ___ For how long? __hours __minutes

Do you do any form of resistance exercises on a consistent basis? (lift weights/tubing) yes no

Do you ever experience pain after exercising? Yes no If so, where? _____

**What other things have you done to improve your health and well-being? (Circle those that apply) Massage
Acupuncture Meditation Homeopathy Herbs Detox/Cleanse Eat organic food Probiotics**

Do you think you need to take a multi-vitamin? YES NO Do you take vitamins daily? Yes No

Are you presently or have you ever been on blood thinning medications? yes no

List all current supplements (vitamins &/or herbs).

1. (brand of multivitamin) _____ 2. _____

3. _____ 4. _____

List all current medication and the reason for taking it (prescription & over-the-counter)ex: tylenol for headaches

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Major surgeries/operations/hospitalizations: if you need more space, use the back of this page

1. _____ date _____ 2. _____ date _____

3. _____ date _____ 4. _____ date _____

Traumas and accidents: (auto, sports, broken bones, falls, etc.) Any accidents you have had from birth to now

1. _____ date _____ 2. _____ date _____

3. _____ date _____ 4. _____ date _____

Family history: list all major illnesses and the family relationship to you (maternal or paternal)

1. _____ 2. _____

3. _____ 4. _____

Name _____ Date: _____ Referred by _____

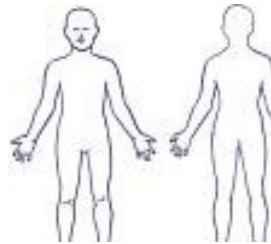
Occupation _____ Employer _____ Full time or Part time

Reason for visit: Spinal Check up OR ***PRIMARY COMPLAINT*** – Describe your primary area of complaint?

When did this health concern **begin and how?**

Describe the **quality** of the sensation: Sharp Ache Throbbing Burning Tingling Numbness Stabbing

Please mark on the picture where you have pain (symptoms)



Rate the severity of your pain 1 = mild pain or discomfort 10 = severe pain 1 2 3 4 5 6 7 8 9 10

How often are you **aware** of this sensation? Circle one. Constant (75%-100%) Frequent (51%-75%) Occasional (26%-50%) Intermittent (0-25%)

What activities are difficult to perform? sitting standing walking bending lying down

What makes it feel **better**? _____ nothing

What makes it feel **worse**? _____ nothing

Has this feeling been: getting better getting worse staying the same coming and going

Have you **stopped doing anything** since the onset? _____

Have you ever **had anything similar**? Explain _____

Is this injury or illness work-related? _____ If yes, have you reported this to your employer? _____

Is this injury or illness related to an automobile accident? _____

On a scale of 1–10, please rate your commitment to a healthy lifestyle, 10 being the highest commitment: _____

Have you **consulted any type of doctor** for this concern? _____

Type of Care: _____ Results? _____

Medical Doctor: _____

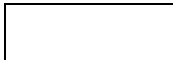
List previous chiropractors (if any) you have seen: _____

Year of last visit to previous chiropractor? _____ Have you ever been to a Gonstead Chiropractor? Yes no

I would like to receive appointment reminders via e-mail yes e-mail: _____ no

I would like to receive appointment reminders via text messaging yes cell# _____ no

Your e-mail address (we will NOT give this to anyone else) _____



_____	_____
Last name	First name
_____	_____
Social Security #	Date of Birth
_____	_____
Home Phone	Cell Phone

Our mission is to provide the highest quality, affordable chiropractic care. With dedication, we promote a better quality of life.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize Goble Heal Chiropractic to release any information to my insurance company/attorney acquired in the course of my examinations or care. I understand that a photocopy of the above assignment and authorizations will be deemed as valid as the original. **I have also been notified of my privacy rights through the HIPAA privacy laws. (see Notice of Information Practices and Privacy Statement)**

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals. Chiropractic does not diagnose or treat disease. Chiropractic has only one goal: *to locate, analyze, and correct spinal interference to the nervous system (nerve pressure)*. The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The *SUBLUXATION (spinal misalignment producing nerve interference)*, in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment, allows the body to function at its optimum level. This allows the inborn healing power of the body to work at maximum efficiency to restore, maintain and promote natural health. We do not diagnose condition(s) or disease(s) other than vertebral subluxations. We offer no treatment of condition(s) or disease(s) other than vertebral subluxations. We promise no cure from any condition(s) or disease(s).

I, _____, having read the above statement, and understanding it fully, do undertake chiropractic health care on this basis.

Patient's

Signature _____ **DATE** _____

Guardian or Spouse's

Signature _____ **DATE** _____

1. Please list your Health Goals, for example, you may want to take strokes off your golf game, etc. _____

2. Are you interested in: **pain control** **joint health** or **overall well being** or _____

3. Please complete this sentence: I view health as (or the definition of health is):

4. These are the things that I am most concerned about in visiting a chiropractor:
