

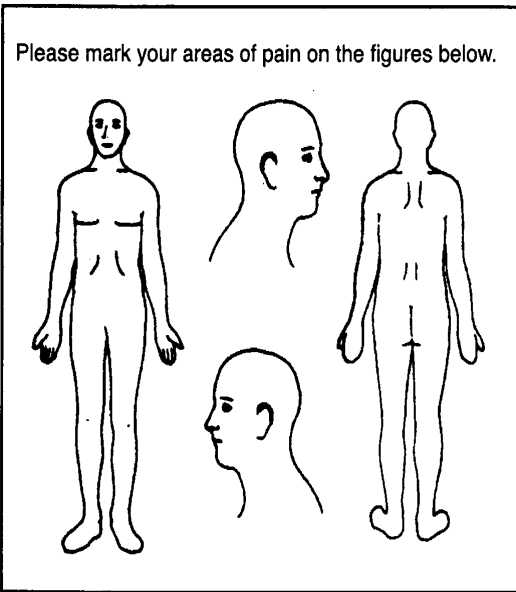
LAST NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 OCCUPATION _____
 EMPLOYER _____
 # OF CHILDREN _____ PHONE _____ CELL _____

FIRST NAME _____ PREFERRED _____
 SS# _____ BIRTHDATE _____ AGE _____
 EMAIL _____
 SPOUSE _____
 SPOUSE'S OCCUPATION _____
 REFERRED BY _____

MY GOAL FOR CONSULTING WITH THE DOCTOR: Temporary Relief Lasting Correction Let Doctor Recommend The Best Type of Care

What is your major complaint? _____
 Timing 0-25% 26-50% 51-75% 76-100% of the time
 What caused it? How did it start? (Gradual/Injury) _____
 Was it related to a work or auto accident? _____
 When was the first time you became aware of this problem? How long have you had it? _____
 Constant Comes and Goes _____ Is it progressively getting worse? Yes No
 Medications you are on now: _____
 What makes it better? _____ Worse? _____
 Describe the problem when it is at its worst? (Check all that apply) Dull Achy Sharp Shooting Refers into my arms
 Refers into my legs Other _____

What activity would you like to be able to do again that is difficult or that **YOU CANNOT DO NOW?** _____
 This was a new/old illness. What Treatment have you had? _____



Please mark your areas of pain on the figures below.

Mark any other symptoms you have had in the past 6 months.
Rate the severity of your problem: 1-10 (1—slight problem, 10—severe problem) pain.
 Leave blank if doesn't apply

- | | | |
|----------------------------------|-------------------------|---------------------------|
| _____ Neck Problems | _____ Walking Problems | _____ Allergies |
| _____ Shoulder Problems | _____ Broken Bones | _____ Hay Fever |
| _____ Arm Problems | _____ Muscle Cramps | _____ Asthma |
| _____ Numbness - Arms | _____ Weak Muscles | _____ Exzema |
| _____ Pain Between Shoulders | _____ Dizziness | _____ Shingles |
| _____ Low Back Problems | _____ Fainting | _____ Nausea |
| _____ Leg Problems | _____ Forgetfulness | _____ Poor Digestion |
| _____ Numbness - Legs | _____ Depression | _____ Ulcers |
| _____ Loss Of Feeling | _____ Vision Problems | _____ Diarrhea |
| _____ Stiff Joints | _____ Ear Pain / Noises | _____ Constipation |
| _____ Painful Joints | _____ Ear Infections | _____ Kidney Infection |
| _____ Restricts Daily Activities | _____ Hearing Loss | _____ Menstrual Cramps |
| _____ Restricts Regular Exercise | _____ Frequent Colds | _____ Diabetes |
| _____ Knee Pain | _____ Wrist Pain | _____ Blood Pressure |
| _____ Ankle Pain | _____ Elbow | _____ High / Low |
| _____ Dificulty Speling | _____ Headaches | _____ Tiredness / Fatigue |
| _____ Sore Muscles | | _____ Foot Pain |

Surgeries/Hospitalization _____

TRAUMA FROM BIRTH TO PRESENT, PLEASE LIST BY DATE/DESCRIBE

Have you had an MRI/CT Scan? _____ Dates _____

1) Injuries or Falls _____

Previous Chiropractic Care _____

2) Broken Bones _____

Date of last adjustment _____

3) Car/Bike Accidents _____

Female: Are you pregnant at this time? Yes No Due Date _____

Do you have any metal in your body? Yes No

Do you have a pacemaker? Yes No

If yes, where? _____

Primary care physician: _____

Phone number: _____

Physical/Massage Therapist: _____

Phone number: _____

Personal Trainer: _____

Phone number: _____

Signature: _____ Date: _____

Elbow -

- Flex - 160
- Ext. - 0
- Pronation - 90
- Supination - 90

Wrist -

- Flex - 90
- Ext. - 70
- Ulnar Deviation - 65
- Radial Deviation - 20

Doctor's Notes:

Shoulder ROM -

- Flex - 180
- Ext. - 60
- Abd - 150
- Add - 35
- Internal Rotation - 90
- External Rotation - 90

Hip -

- Flex - 125
- Ext. - 15
- Add - 45
- Abd - 45
- External Rotation - 45
- Internal Rotation - 45

Ankle -

- Plantar Flexion - 80
- Dorsiflexion—20

Knee -

- Flexion - 130
- Ext. - 0

Health History of Family Members

The reason for this form is to assist the doctor by providing past health history information for his review

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Drinker							
Drug Addiction							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Neuritis							
Neuralgia							
Pinched Nerve							
Sinus Trouble							
Smoker							
Sports Activities							
Stomach Trouble							
Deceased							

Name: _____

Date: _____



Date: _____

Consent to Care For Minor Child

I hereby authorize Acton Family Chiropractic, and whomever she/he/they may designate as assistants to administer chiropractic care as she/he/they deems necessary to my child/minor/ward.

Name of Minor Patient

Signature of Parent/Guardian

Signature of Witness