Collins Chiropractic, Inc.
555 Fourth Street, Suite # 1 Clovis, CA 93612
559-323-5000 FAX: 559-323-5525

Date: _____

Name: _____ Address: _____

City: _____State:_____ Zip: _____

Hm. phn: (___) _____ Cell: (___) _____ E-mail:_____

SSN: _____-_____-_____ Date of birth: _____ Age: _____ Ht: _____ Wt: _____

__Male __Female # of Children: _____Name of spouse: _____

Emergency Contact: _____ Relationship: _____ Phone Number: ( ) _____

Employer: _____ Address: _____

City: _____State: _____Zip: _____Wk phn: _____Occupation: _____

How were you referred to our office? __Internet __Mail __Friend/Family __TV Other: _____

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1. Have you ever had Chiropractic care before? Yes / No If yes, When? _____

2. If you are experiencing any health problems, please list your chief complaints in order of severity.

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

4. _____ For how long? _____

Has this problem been getting worse or staying the same? _____

3. Currently or in the past have you ever experienced any of these complaints while working? _____ if yes, please describe what activities at work may be causing you to experience these complaints: _____
_____

4. Are there any other activities, incidents, or events outside of work that may have caused these complaints? Y / N
If yes, please explain: _____

5. Have you at any time in the past ever suffered a work injury? Y / N If yes, what is the date of injury? _____

6. Have you been involved in an auto accident in the last 12 months? Yes / No
If yes, what is the date of the auto accident? _____

7. Have you ever had any surgeries or hospitalizations? Yes / No If yes, please list: _____

8. Please indicate medications (over the counter) prescriptions you are currently taking: __Aspirin/Tylenol __Pain killers __Muscle Relaxers __Insulin __Tranquilizers __Birth Control Pills __Others _____

9. Health Insurance Co. Name: _____
10. Name of Spouse's health insurance (if applicable): _____

PLEASE CHECK ALL PRESENT SYMPTOMS.

Name: _____
Date: _____

HEAD:
□ Headache
  □ Sinus (allergy)
  □ Entire head
  □ Back of head
  □ Forehead
  □ Temples
  □ Migraine
□ Loss of memory
□ Light-headedness
□ Light bothers eyes
□ Loss of taste
□ Loss of balance
□ Dizziness
□ Loss of hearing
□ Ringing in ears

NECK:
□ Pain in neck
□ Neck pain with movement
□ Forward
□ Backward
□ Turn to left
□ Turn to right
□ Bend to left
□ Bend to right
□ Pinched nerve in neck
□ Muscle spasms in neck
□ Arthritis in neck

SHOULDERS:
□ Pain in shoulder joint (R-L)
□ Pain across shoulders
□ Can't raise arm
□ Above shoulder level
□ Over head
□ Tension in shoulders

ARMS & HANDS:
□ Pain in upper arm
□ Pain in elbow
□ Pain in forearm
□ Pain in hands
□ Pain in fingers
□ Sensation of pins & needles in arms
□ Sensation of pins & needles in fingers
□ Numbness in fingers (R-L)
□ Fingers go to sleep
□ Hands cold
□ Swollen joints in fingers
□ Arthritis in fingers
□ Loss of grip strength

MID-BACK:
□ Mid-back pain
□ Pain between shoulder blades
□ Muscle spasms

CHEST:
□Chest pain
□ Shortness of breath
□ Pain around ribs

ABDOMEN:
□ Nausea
□ Gas
□ Constipation
□ Diarrhea

LOW BACK:
□ Low back pain
  □ Upper lumbar
  □ Lower lumbar
  □ Sacroiliac
□ Low back pain is worse when:
  □ Lifting
  □ Standing
  □ Sitting
  □ Bending
  □ Coughing
  □ Lying down (sleeping)
  □ Walking
□ Pain relieves when_____
□ Slipped disk
□ Muscle spasms
□ Arthritis

HIP, LEGS & FEET:
□ Pain in buttocks (R-L)
□ Pain in hip joint (R-L)
□ Pain down leg (R-L)
□ Knee pain
  □ Inside
  □ Outside
□ Leg cramps
□ Cramps in feet (R-L)
□ Pins & Needles in legs (R-L)
□ Numbness of leg (R-L)
□ Numbness of feet (R-L)
□ Numbness of toes
□ Feet feel cold
□ Swollen ankles (R-L)
□ Swollen feet (R-L)

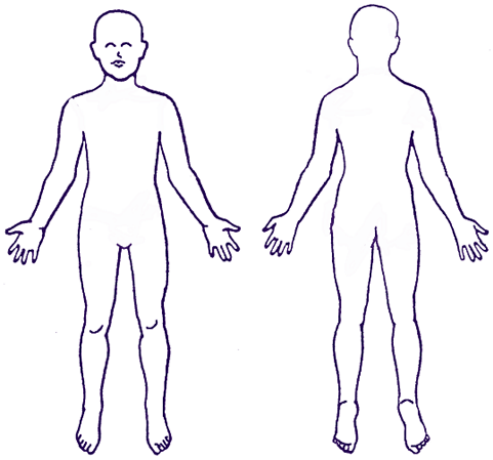
WOMEN ONLY:
□ Menstrual pain _____(where)
□ Cramping
□ Irregularity
□ Birth control _____ (type)
□ Hysterectomy
□ Menopausal hot flashes

MALE ONLY:
□ Prostate trouble
□ Difficult urination

GENERAL:
□ Nervousness
□ Irritable
□ Depressed
□ Chronic Fatigue / Drowsy
□ Generally feel run-down

OTHER:
□ Indigestion ½ -1 hour after eating, may last 3-4 hrs.
□ Lower bowel gas and or bloating several hrs after eating
□ Insomnia
□ Sensitive to cold
□ Poor circulation
□ Increased blood pressure

PAIN DIAGRAM:
If you are experiencing any health problems, please mark the exact location of your pain in the diagram below.



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