BACK IN MOTION CHIROPRACTIC, LLC ♦ DISCOVERY CHIROPRACTIC, LLC
4341 B Street ♦ Ste 100 ♦ Anchorage, AK 99503
Phone: 907-562-(CARE) 2273 ♦ Fax: 907-562-2263♦ www.backinmotionak.com

Patient Name (Please print):_____ **Date:**_____

The symptom(s) that have prompted me to seek care today include:_____

_____

_____

And are the result of: ☐ Injury – Recreational - Work related - Automobile/Personal Injury (please circle)

☐ Worsening/long term problem ☐ Reoccurrence of previous injury/illness ☐ Other:_____

Onset (When did you first notice your CURRENT symptoms?)

_____

Are your symptoms getting: ○ Better ○ Worse

Duration and Timing (How often do you feel it?)

○ Constant ○ Comes and goes

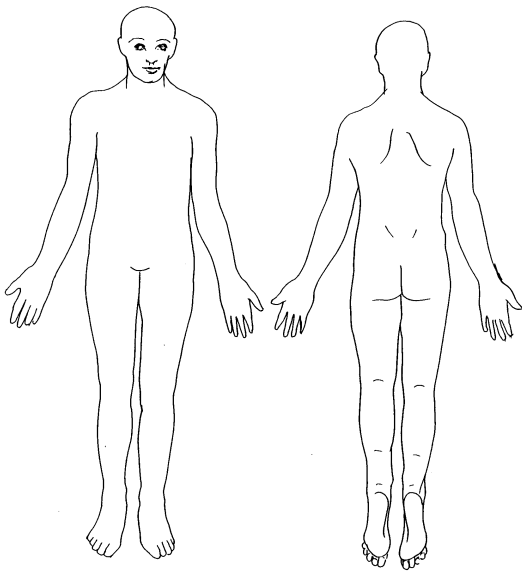
How often (times per day/week)? _____

Intensity (How extreme are your symptoms?) Please circle: **0 1 2 3 4 5 6 7 8 9 10**

Quality of Symptoms
(What does it feel like?)

- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Stabbing
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Sharp
- ○ Aching
- ○ Dull
- ○ Pinching
- ○ Boring
- ○ Soreness
- ○ Weakness
- ○ Tender
- ○ Deep
- ○ Superficial

Location (Where does it hurt?)
Indicate the area(s) on the drawing.



Radiating pain (Does it affect other areas of your body? Where does it radiate, shoot or travel?)_____

_____

Aggravating or Relieving Factors (What makes it better or worse):

Better	Worse	
☐	☐	Morning
☐	☐	Afternoon
☐	☐	During sleep hours
☐	☐	Standing from sitting
☐	☐	Bending
☐	☐	Lying down flat
☐	☐	Sitting
☐	☐	Exercise/Stretching
☐	☐	Walking
☐	☐	Standing
☐	☐	Desk/Computer work
☐	☐	Medication:_____
☐	☐	Other:_____

Dr's Notes:

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REVIEW OF SYSTEMS

MUSCULOSKELETAL

Had	Have	
○	○	Osteoporosis
○	○	Arthritis
○	○	Scoliosis
○	○	Neck Pain
○	○	Back Problems
○	○	Hip disorders
○	○	Knee injuries
○	○	Foot/Ankle pain
○	○	Shoulder problems
○	○	Elbow/wrist pain
○	○	TMJ issues
○	○	Poor posture
○	○	Other_____

_____

_____

NEUROLOGICAL

Had	Have	
○	○	Anxiety
○	○	Depression
○	○	Headache
○	○	Dizziness
○	○	Pins and needles
○	○	Numbness
○	○	Tingling

RESPIRATORY

Had	Have	
○	○	Asthma
○	○	Apnea
○	○	Emphysema
○	○	Hay fever
○	○	Shortness of breath
○	○	Pneumonia

CARDIOVASCULAR

Had	Have	
○	○	High blood pressure
○	○	Low blood pressure
○	○	High cholesterol
○	○	Poor circulation
○	○	Angina
○	○	Excessive bruising

DIGESTIVE

Had	Have	
○	○	Anorexia / Bulimia
○	○	Ulcer
○	○	Food Sensitivities
○	○	Heartburn / Acid reflux
○	○	Constipation
○	○	Diarrhea

SENSORY

Had	Have	
○	○	Blurred vision
○	○	Ringing in ears
○	○	Hearing loss
○	○	Chronic ear infection
○	○	Loss of smell
○	○	Loss of taste
○	○	Hearing aids
○	○	Corrective lenses / Contact lenses

ENDOCRINE

Had	Have	
○	○	Thyroid issues
○	○	Immune disorders
○	○	Hypoglycemia
○	○	Frequent infections
○	○	Swollen glands
○	○	Low energy

INTEGUMENTARY (SKIN)

Had	Have	
○	○	Skin cancer
○	○	Psoriasis
○	○	Eczema
○	○	Acne
○	○	Hair loss
○	○	Rash
○	○	Edema / Swelling

GENITOURINARY

Had	Have	
○	○	Kidney stones
○	○	Infertility
○	○	Prostate issues
○	○	PMS symptoms

CONSTITUTIONAL

Had	Have	
○	○	Fainting
○	○	Poor appetite
○	○	Fatigue
○	○	Sudden weight gain /loss (circle one)
○	○	Weakness

Dr's Notes:_____

_____

_____

_____

_____

_____

_____

_____

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Patient Name (Please print):_____ **Date:**_____

ILLNESS (Check the illnesses you have **Had** in the past or **Have** now.)

Had	Have	
○	○	AIDS
○	○	Alcoholism
○	○	Allergies
○	○	Arteriosclerosis
○	○	Cancer
○	○	Chicken pox
○	○	Diabetes
○	○	Epilepsy
○	○	Glaucoma
○	○	Goiter
○	○	Gout
○	○	Heart disease
○	○	Hepatitis
○	○	HIV positive
○	○	Malaria
○	○	Measles
○	○	Multiple Sclerosis
○	○	Mumps
○	○	Polio
○	○	Rheumatic fever
○	○	Scarlet fever
○	○	Sexually transmitted disease
○	○	Stroke
○	○	Tuberculosis
○	○	Typhoid fever
○	○	Ulcer
○	○	Other:_____

TREATMENTS (Check the ones you've received in **Past** or are receiving **Currently)**

Past	Current	
○	○	Acupuncture
○	○	Antibiotics
○	○	Blood transfusions
○	○	C Pap or Bi-Pap machine
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Cortisone injections
○	○	Dialysis
○	○	Epidural injections
○	○	Homeopathy / Naturopathic care
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Other:_____

NUTRITIONAL SUPPLEMENTS / VITAMINS / HERBS

Please list ALL that you are currently taking:_____

_____

_____

MEDICATIONS Please list ALL current prescription & over the counter that you are currently taking:_____

_____

_____

ALLERGIES Please list ALL allergies: _____

_____

Dr's Notes

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HISTORY OF INJURY/ FRACTURES/ SURGERIES

PLEASE INDICATE YEAR IF CHECKED: (example – 1987) and CIRCLE R (right) or L (left) if indicated

PREVIOUS INJURIES: ☐ I have no history of previous painful injury. _____(patient's initial's)

☐ Work Injury_____ ☐ Car/Motorcycle Accident_____ ☐ Sports Injury_____

☐ Head Injury_____ ☐ Headaches/Migraines_____ ☐ Other_____

FRACTURES/BROKEN BONES: ☐ I have no history of fractures/broken bones. _____ (patient's initials)

☐ Arm/wrist/ hand_____ R L ☐ Collar (clavicle)_____ R L ☐ Hip/pelvis_____ R L

☐ Leg/knee/foot_____ R L ☐ Nose/facial_____ ☐ Spinal Vertebrae_____

☐ Ribs_____ ☐ Other: _____

PREVIOUS SURGERIES: ☐ I have no history of previous surgeries. _____ (patient's initial's)

☐ Appendix_____ ☐ Gallbladder_____ ☐ Eye_____ R L ☐ Ear_____ R L

☐ Head/Brain_____ ☐ Heart_____ ☐ Hernia: hiatal / inguinal _____

☐ Disc/Spine: Neck_____ Back_____ Pelvis_____ ☐ Spinal Cord/Nerve_____

☐ Leg/knee/hip_____ R L ☐ Shoulder_____ R L ☐ Collar bone (clavicle)_____ R L

☐ Arm/wrist/ hand_____ R L ☐ Tonsillectomy_____ ☐ Wisdom teeth_____

☐ Hysterectomy – complete_____ uterus only_____ ☐ Cosmetic_____

☐ Breast Implants_____ ☐ Vasectomy_____ ☐ Other_____

☐ Cancer_____ Please list what type and treatment:_____

Dr's Notes

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FAMILY HISTORY

Relative	Age if living	State of health good	poor	Illnesses	Age at time of death	Cause of death illness	natural
Mother	_____	O	O	_____	_____	O	O
Father	_____	O	O	_____	_____	O	O
Sister 1	_____	O	O	_____	_____	O	O
Sister 2	_____	O	O	_____	_____	O	O
Brother 1	_____	O	O	_____	_____	O	O
Brother 2	_____	O	O	_____	_____	O	O
_____	_____	O	O	_____	_____	O	O
_____	_____	O	O	_____	_____	O	O

Are there any hereditary health issues that you know about ?_____

_____

SOCIAL HISTORY (Tell us about your health habits and stress level)

Alcohol use O Never O Daily O Weekly How much? _____ O Beer O Wine O Liquor

Coffee use O Never O Daily O Weekly How much? _____

Soft drinks O Never O Daily O Weekly How much? _____

Water intake O Never O Daily O Weekly How much? _____

Tobacco use O Never O Daily O Weekly How much? _____ O Quit _____ When _____
O Pipe O Cigar O Chew O Cigarettes

Recreational Drugs O Never O Daily O Weekly How much? _____ O Quit _____ When _____

Exercise O Never O Daily O Weekly How much?_____ What type:_____

_____

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ACTIVITIES OF DAILY LIVING

	No effect	Mild effect	Moderate effect	Severe effect			No effect	Mild effect	Moderate effect	Severe effect
Sitting						Grocery shopping				
Rising out of chair						Household chores				
Standing						Lifting objects				
Walking						Reaching overhead				
Lying down						Showering/bathing				
Bending over						Dressing myself				
Climbing stairs						Love life				
Using a computer						Getting to sleep				
Getting in/out of car						Staying asleep				
Driving a car						Concentrating				
Looking over shoulder						Exercising				
Caring for family						Yard work				

How does this condition currently interfere with your life and ability to function?_____

_____

How does your current condition interfere with your:

- Work or career? ☐ Y ☐ N In what way? _____
- Recreational activities? ☐ Y ☐ N In what way? _____
- Household responsibilities? ☐ Y ☐ N In what way? _____
- Personal relationships? ☐ Y ☐ N In what way? _____

How much sleep do you average per night? _____ Hours

- Preferred sleep position: ☐ Back ☐ Stomach ☐ Side lying
- Do you awake feeling rested? ☐ Y ☐ N
- Is your sleep disrupted due to current condition? ☐ Y ☐ N