WELCOME

Carlyle Chiropractic Clinic, P.C.

Date:_____Legal Name: _____Nick Name:_____

Date of Birth: _____ Social Security #_____Sex: F ☐ M ☐ Employer:_____

Address: _____City:_____ State: _____Zip Code: _____

E-mail: _____Spouse's Name: _____ DOB: _____

Telephone Number(s): Home: _____ Cell: _____ Business: _____

Patient Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other

Referred By: _____ Have you ever seen a chiropractor? ☐ Yes ☐ No

Please complete the following questions to the best of your ability:

What brings you to the clinic?_____

What caused your condition?_____

What makes it better?_____ What makes it worse?_____

Have you seen any other doctors for this condition?_____Did it help? _____

Are there any complicating factors? (Surgeries, medications, injuries)_____

Are you healthier now than you were 5-years ago? _____

Has a doctor ever put you on a Wellness Program?_____

Please mark the intensity of your pain today.

0 - NO PAIN

10 - INTENSE PAIN

Example Neck

O 1 2 3 ④ 5 6 7 8 9 10

1. _____

O 1 2 3 4 5 6 7 8 9 10

2. _____

O 1 2 3 4 5 6 7 8 9 10

3. _____

O 1 2 3 4 5 6 7 8 9 10

DOCTORS USE ONLY

_____

_____

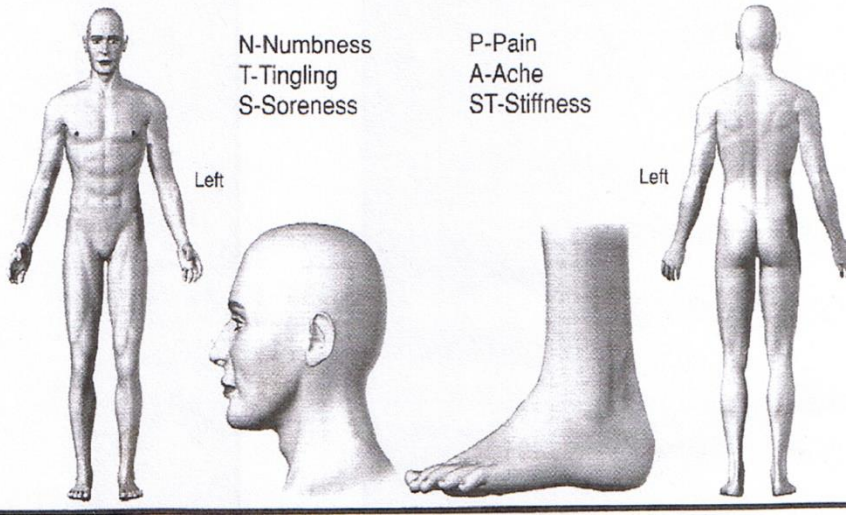
_____

_____

Please mark area & type of pain on the drawings using the codes listed below.

N-Numbness
T-Tingling
S-Soreness

P-Pain
A-Ache
ST-Stiffness



Please Complete Reverse Side

Please "X" all symptoms that you have had, even if they do not seem related to your current problem.

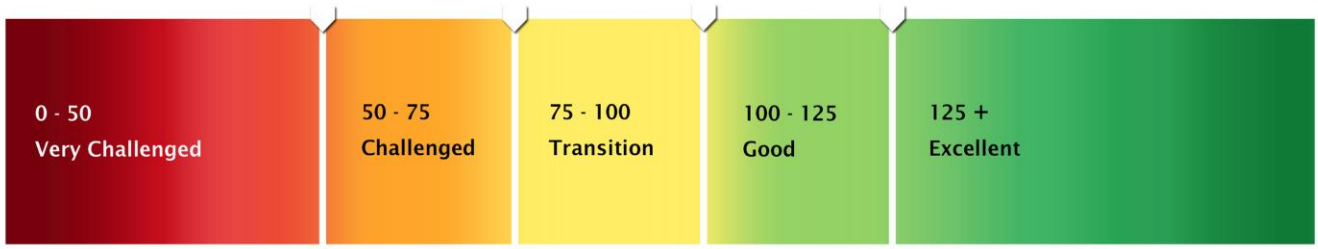
__ Acne
__ Alcohol Consumption
__ Allergies*
__ Alzheimer's Disease
__ Anemia
__ Anxiety
__ Arthritis
__ Asthma
__ Back Pain
__ Bladder Infections
__ Bronchitis
__ Bruise Easily
__ Burns
__ Caffeine Consumption
__ Caffeine Sensitivity
__ Calcium Deficiency
__ Cancer *(type)* _____
__ Candida / Thrush
__ Cellulite Accumulation
__ Chronic Fatigue
__ Chronic Sore Throats
__ Circulation *(poor)*
__ Colitis
__ Congestive Heart Failure
__ Constipation
__ Crohn's Disease
__ Depression
__ Dermatitis
__ Diabetes __Type 1 or __Type2
__ Digestive Problems
__ Diverticulitis
__ Dry Skin
__ Eczema
__ Fatty Food Consumption
__ Fibromyalgia
__ Gall Bladder Disease
__ Gall Stones
__ Gas
__ Gout
__ Hay fever
__ Headaches
__ Heart Attack
__ Heart Disease
__ Heartburn
__ Hepatitis
__ Hernia
__ Hiatus-Hernia
__ High Blood Pressure
__ High Cholesterol
__ High Triglycerides
__ Hormone Imbalance
__ Hot Flushes
__ Hyperactivity *(ADD/ADHD)*
__ Hypoglycemia *(low blood sugar)*
__ IBS *(Irritable-Bowel Syndrome)*
__ Infections
__ Insomnia *(unable to sleep)*
__ Iron Deficiency
__ Kidney Disease
__ Kidney Stones
__ Low Energy
__ Lupus
__ Menopausal
__ Menstrual
__ Migraines
__ Mood Swings
__ Multiple Sclerosis
__ Muscle-Tension
__ Nursing Mothers
__ Osteoporosis
__ Pain
__ PMS
__ Poor Health
__ Pregnant
__ Psoriasis
__ Recent Surgery
__ Respiratory / Breathing Disorders
__ Sinus Problems
__ Skin Disorder
__ Sleep Apnea
__ Sleep Disorder
__ Smoking/How Much_____
__ Spasms
__ Stress Levels _Low _Med _High
__ Stretch Marks
__ Thyroid
__ Ulcers
__ Unhealthy Gums
__ Varicose-Veins
__ Water Retention/Bloating
__ Weak Immune System
__ Wrinkles
__ Yeast Infections
__ other please specify:
_____

Health Goal:

_____ Out of Pain _____Fix the Problem Better Quality of Life:_____

Biological Age vs. Chronological Age:

1. Using the Creating Wellness Quotient scale (below), place an (X) on the scale where you think you are right now.
2. Place a circle (O) on the scale where you would like to be.
3. How long do you think it will take you to achieve this result? _____



*Allergies_____

Please list Medications by Specific Drug Name and other comments below:

_____

_____

_____

_____

_____

Thank you for your assistance in determining your treatment plan.