Name ______________________________________ Date __________________

What are your reasons for seeking chiropractic care?

____

Chief Complaint 1. Location ____

2. When did this begin? ____

3. How did this begin? ____

Circle all that apply to the quality of complaint/pain?

Dull Ache Sharp Shooting Burning Throbbing Deep Nagging Other

Further description, if necessary ____

Does this complaint/pain radiate or travel to other areas of the body? N Y, to where__________________

Do you have any numbness or tingling associated with this complaint/pain? N Y, to where______________

What is the intensity/severity (1 best – 10 worst)? __________

How frequent is the complaint/pain (circle all that apply)? Daily Weekly Monthly Other_________

How long does it last (circle all that apply)? Seconds Minutes Hours

What activity makes it worse (circle all that apply)?

Work	Exercise	Reading	Diet	Personal
Walking	Standing	Squatting	Twisting	Lying down
Sitting	Bending	Lifting	Running	Driving

Other_________________________

What activity makes is better (circle all that apply): Home Work Exercise Diet Personal

Walking	Standing	Squatting	Twisting	Laying Down	Reading
Sitting	Bending	Lifting	Running	Driving	Other ________

Previous Intervention

What have you tried to fix the problem?

1. Medications: _____________________ 3. Other Physicians: _______________________

2. Surgery: _____________________ 4. Treatments: _______________________

Past Health History

Previous Illness When ____________________ Type _________________________

Previous Trauma/Injury ____

Have you had any broken bones? When ____________________ Where ________________________

Allergies ____

Current Medications ____

Surgeries Date ____________________ Type ________________________

Females Have you had any pregnancies? ___________ How many? __________

Vaginal or C Section Complications? ___________________________

Family Health History (circle all that apply)

Mother Side

Heart Disease Diabetes
Cancer Arthritis
Autoimmune Disorders

Father Side

Heart Disease Diabetes
Cancer Arthritis
Autoimmune Disorders

Other____

Social Occupation

Job Description ____

Recreational Activities ____

What are your current primary sources of stress? ____

What do you do in order to manage stress and take care of yourself? ___________________________________

What is your exercise routine? ____

Diet; please describe a typical day's diet for you. Don't forget beverages.

Breakfast	Lunch	Dinner	Snacks (what hour)

Sources and amounts of caffeine ____

alcohol _______________________________ smoking _______________________

I have the read the above information and certify it to be true, and correct to the best of my knowledge. I authorize Life Line Chiropractic to provide my consultation to determine my eligibility to receive treatment within this office.

Signature ____ Date _______________________

FOR OFFICE USE ONLY

Doctor: **Tammy Costello, DC**

Patient is: Accepted for care Denied for care

Current Recommendations:

Cervical Exam	X-rays /Area _______
Lumbar Exam	Hydrotherapy
Thoracic Exam	Ice/ Stim
Upper / Lower Extremity Exam	Adjust today
Massage Therapy	Aqua Chi
Other ____________	

____________ I accept the recommendations set forth by the doctor, and wish to begin chiropractic treatment.