Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

☐ Pneumonia
☐ Rheumatic Fever
☐ Polio
☐ Tuberculosis
☐ Whooping Cough
☐ Anemia
☐ Measles
☐ Mumps
☐ Smallpox
☐ Chicken Pox
☐ Diabetes
☐ Cancer
☐ Heart Disease
☐ Thyroid
☐ Influenza
☐ Pleurisy
☐ Arthritis
☐ Epilepsy
☐ Mental Disorders
☐ Lumbago
☐ Eczema

INTAKE
☐ Coffee
☐ Tea
☐ Alcohol
☐ Cigarettes
☐ White Sugar

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULOSKELETAL CODE
☐ Low Back Pain
☐ Pain Between Shoulders
☐ Neck Pain
☐ Arm Pain
☐ Joint Pain/Stiffness
☐ Walking Problems
☐ Difficulty Chewing/Clicking Jaw
☐ General Stiffness

NERVOUS SYSTEM CODE
☐ Nervous
☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Confusion/Depression
☐ Fainting
☐ Convulsions
☐ Cold/Tingling Extremities
☐ Stress

GENERAL CODE
☐ Fatigue
☐ Allergies
☐ Loss of Sleep
☐ Fever
☐ Headaches

GASTROINTESTINAL CODE
☐ Poor/Excessive Appetite
☐ Excessive Thirst
☐ Frequent Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Liver Problems
☐ Gall Bladder Problems
☐ Weight Trouble
☐ Abdominal Cramps
☐ Gas/Bloating After Meals
☐ Heartburn
☐ Black/Bloody Stool
☐ Colitis

GENITO-URINARY CODE
☐ Bladder Trouble
☐ Painful/Excessive Urination
☐ Discolored Urine

C-V-R CODE
☐ Chest Pain
☐ Short Breath
☐ Blood Pressure Program
☐ Irregular Heartbeat
☐ Heart Program
☐ Lung Program/Congestion
☐ Varicose Veins
☐ Ankle Swelling
☐ Stroke

EENT CODE
☐ Vision Programs
☐ Dental Programs
☐ Sore Throat
☐ Earaches
☐ Hearing Difficulty
☐ Stuffed Nose

FEMALES ONLY:
Date of last period:

_____

Are you pregnant?
☐ Yes ☐ No

MALE/FEMALE CODE
☐ Menstrual Irregularity
☐ Intense Menstrual Cramps
☐ Vaginal Pain/Infection
☐ Breast Pain/Lumps
☐ Prostate Sexual Dysfunction
☐ Other Problems:

_____

_____

_____

FAMILY HISTORY
The following members have the same or similar problem(s) as I do:
☐ Mother
☐ Father
☐ Brother
☐ Sister
☐ Spouse
☐ Child

ACTIVITIES OF DAILY LIVING IMPAIRMENT

Dear Patient:

Please be aware that the purpose of this examination is to determine your level of impairment. Impairment is defined as the loss of, loss of use of, or derangement of any part, system, or function. Disability is the limiting loss or absence of the capacity of an individual to meet personal, social, or occupational demands, or to meet statutory or regulatory requirements.

Please read the following directions and complete the impairment checklist. In terms of a normal day where you are active 16 hours and sleep 8 hours, "occasionally" means up to 33% of the day, "frequently" means 34% to 66% of the day, "continuously" means 67% to 100% of the day. Please mark how the specific injury(ies) you are being examined for now impair your life in a normal day.

ACTIVITIES OF DAILY LIVING	IMPAIRED			
	Not at All	Occasionally	Frequently	Continuously
Self care & personal hygiene	( )	( )	( )	( )
Normal living postures (sitting, lying down, etc.)	( )	( )	( )	( )
Travel	( )	( )	( )	( )
Sexual function	( )	( )	( )	( )
Social & recreational activities	( )	( )	( )	( )
Communication	( )	( )	( )	( )
Ambulation (moving around)	( )	( )	( )	( )
Non-specialized hand activities	( )	( )	( )	( )
Sleep	( )	( )	( )	( )
Writing	( )	( )	( )	( )
Other_____	( )	( )	( )	( )
Other_____	( )	( )	( )	( )

Signature_____ Date_____

PATIENT PAIN FORM

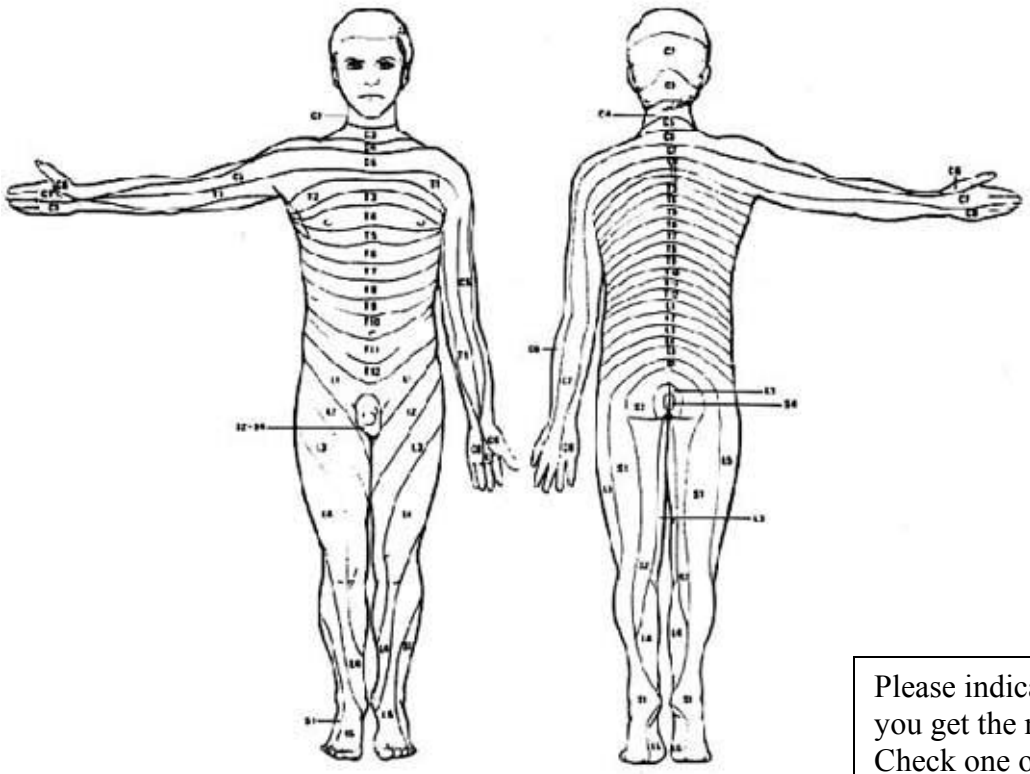
Please circle on this line the level or intensity of pain that you are presently experiencing.

Absolutely _____ Worse pain
Pain Free 1 2 3 4 5 6 7 8 9 10 Imaginable

Mark the areas on your body where you feel the described sensations with the appropriate symbols below. Mark the areas of radiation. Please include all affected areas.

Numbness	Dull Ache	Hot Burning	Sharp/Stabbing	Pins& Needles
= = =	0 0 0	X X X	/ / /	+ + +

(Describe any other discomfort/sensation_____, and use * * * on the affected areas)



Please indicate when you get the most pain. Check one only.

Sitting □
Standing □
Lying down □
Other □
_____

Signed:_____

Date:_____

NEW PATIENT INFORMATION

Welcome to Corinth Chiropractic! Please complete all questions.

Name:			Date:
Address:		City/state/zip:	
Home Phone:		Work:	
Birth date:	Age:	Social Sec. #:	
Marital Status:		Email:	
Your Employer:		Occupation:	
Spouse's Name:		Spouse's Employer:	
Children's Names & Ages:			
Favorite Hobbies & Interests			
Method of Payment for First Visit:	Cash	Check	Credit Card

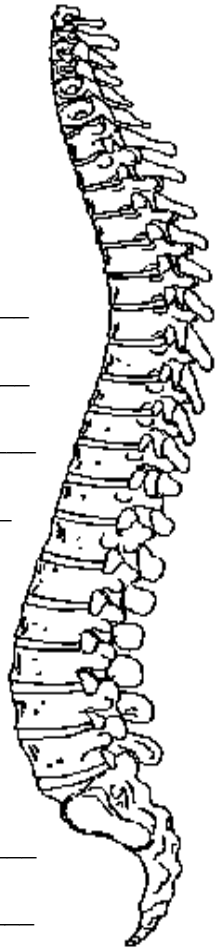
Current Health complaints/reasons for consulting our office:

1._____

2._____

3._____

4._____



Who may we thank for referring you?_____

Have you had same or similar problems before?_____

If so, for how long?_____

Is this the result of an auto or work injury?_____ If so, when?_____

Immediate family with similar problems?_____ If so, who?_____

Other doctors you have seen for this problem:_____

Surgeries you have had:_____

Medications you currently take:_____

Is there any chance you are pregnant:_____

Have you ever been diagnosed with cancer:_____If so, what kind?_____

Do you have health insurance?_____Carrier/policy #_____

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature:_____Date:_____