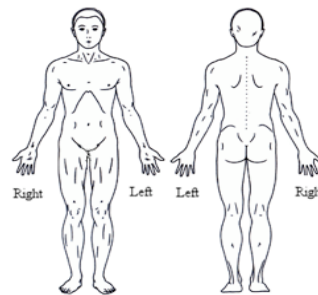


5

Circle below the severity of your pain on a scale of 0 to 10
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

What make your condition better? _____
What makes your condition worse? _____
Does it interfere with your Work Sleep Daily Activity
Activities/movements that are painful to perform:
 Sitting Standing Walking Bending Lying down
 Driving Reading Getting Up Other _____
What time of day is your pain worst? _____

Using the symbols below, mark on the pictures where you feel pain.



Numbness ===
Dull Ache OOO
Burning XXX
Sharp/Stabbing ///
Pins, Needles +++
Other _____ ^^^

6

HEALTH HISTORY

What other treatments have you had for this condition?

Chiropractic Physical Therapy Medication Surgery Orthopedic Neurologist

Name of other doctors who have treated you for this condition _____

Describe the other doctor's treatment for your condition _____

General Practitioner _____ Address and City _____

Date of last physical exam _____ Previous Chiropractic care? Yes No Date _____

List any medications you are taking & what they are treating: _____

Previous Surgeries _____

Vitamins/Herbs/ Minerals _____

Fractures _____

Females Are you Pregnant? Yes No Date of last PAP test _____

Check any of the following conditions you have had: _____ Do you have an Optometrist? _____ Dentist? _____

General History

- Trauma
- Height or Weight change
- Fever/ chills
- Sweats
- Allergies
- Anemia
- Bleeding/bruising
- Fatigue/weakness

Your Family's History

- Diabetes
- Thyroid disease
- Tuberculosis
- Kidney disease
- High blood pressure
- Heart disease/stroke
- Musculoskeletal disease
- Cancer
- Other _____

Gastrointestinal System

- Nausea/vomiting
- Vomiting blood
- Peptic Ulcer
- Indigestion/heartburn
- Abdominal pain/swelling
- Change in stool/color/etc
- Diarrhea
- Hernia
- Hemorrhoids
- Gallbladder disease
- Liver disease
- Pancreatitis
- Alcohol Intake _____ Amount

Endocrine system

- Thyroid problem
- Diabetes
- Neck Surgery/irradiation

Eyes/Ears/Nose/Throat

- Visual problems
- Pain in eyes
- Difficulty hears/hearing/deaf
- Ringing in ears
- Ear Pain
- Nosebleeds
- Sinus Infections
- Difficulty swallowing
- Enlarged painful/glands
- Dental problems

Respiratory System

- Difficulty breathing
- Cough
- Coughing Blood
- Wheezing/asthma
- Tuberculosis/ exposure
- Pneumonia/lung infection

Urinary System

- Frequent urination
- Pain on urination
- Change in urine color
- Difficulty starting stream
- Difficulty in holding stream
- Discharge
- Urinary Tract Infection
- Kidney disease
- Pelvic Pain

Cardiovascular System

- Short breath w/ activity
- Chest pain
- Palpitations
- Fainting
- Sudden calf pain w/ walking
- Rheumatic fever
- Pacemaker

Skin/Hair/Nails

- Skin dryness/wetness
- Rashes/itching/sores
- Skin growths
- Mole changes
- Skin Cancer
- Change in finger nails
- Unusual skin lumps

Neurological System

- Headaches
- Epileptic seizures
- Head Trauma
- Numbness/tingling
- Fainting/ Dizzy

Breasts

- Lumps/masses
- Pain
- Change in shape

All Reviewed by Dr. _____

LIFESTYLE

- Smoking _____ Packs/Day _____
- Alcohol _____ Drinks/Week _____
- Coffee/Caffeine Drinks _____ Cups/Day _____
- High Stress Level _____ Reason _____

EXERCISE

- None
- Mild (1-2 times wk)
- Moderate (3-4 times wk)
- Heavy (5+ wk)

DIET-VITAMINS

Are you on a special diet? _____
Are you vegetarian _____
If yes, are you taking any supplements _____

Would you like information on...

Youth Injury Prevention Yes No
Personal Training Instruction Yes No
Vitamins/Supplements Yes No
Weight Loss Yes No

AUTHORIZAITON

Office policy is that payment is due at the time of service. This includes all co-pays, co-insurance, and deductibles. Insurance verification and authorization is not guarantee of payment. If I choose to utilize my insurance I give permission for P3 Sports Care to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. Should P3 Sports Care be out of network, I will complete an Out Of Network Agreement form and Assignment of Benefits form that will be sent to my insurance to direct them to make payments to P3 Sports Care and send them directly to P3 Sports Care. I clearly understand that I am ultimately personally responsible to pay for all services rendered to me or my dependent.

X _____

Date: _____