Practice Member Initial Health Status

Name ______________________________ Date ______________

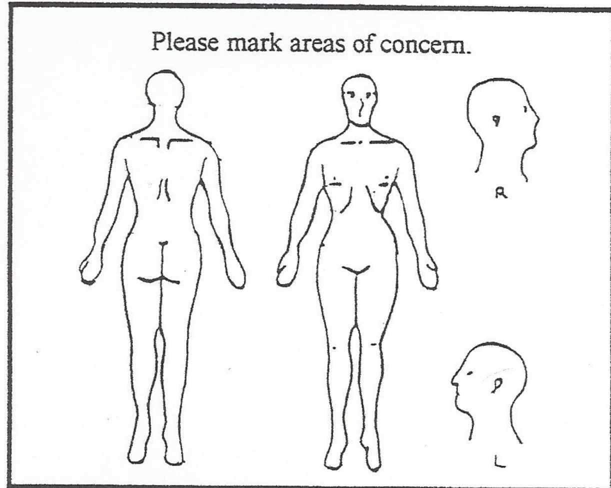
Primary area of concern: ______________
When did it start? ______________
How did it start? ______________
Where does it travel (if applicable)? ______________
Description: dull/sharp/ache/numb/tingle ______

Circle frequency:
constant/frequent/intermittent/occasional
Circle severity:
None 1 2 3 4 5 6 7 8 9 10 worst
Associated symptoms? ______________

Secondary area of concern: ______________
When did it start? ______________
How did it start? ______________
Where does it travel (if applicable)? ______________
Description: dull/sharp/ache/numb/tingle ______

Circle frequency:
constant/frequent/intermittent/occasional
Circle severity:
None 1 2 3 4 5 6 7 8 9 10 worst
Associated symptoms? ______________

Any x-rays/MRI/CT taken:
Of what? ______________ Date ______
Where? ______________
Prior accidents/injuries: ______________
____
Former chiropractic care? ______________
____
Surgeries: ______________ Date ______
Hospitalizations: ______________ Date ______
Vitamins/supplements: ______________
Medication: ______________



Do you have a personal or family history of cancer, diabetes, cardiovascular problems/stroke, high blood pressure? Who? Age of diagnosis?:
____

Outline your current exercise routine. ______________
Which activities are you unable to perform and would like to resume? ______________

Please list any other concerns you would like to discuss with the Doctor. ______________
____

I hereby authorize the associates of Fountain Valley Chiropractic to examine, x-ray, and treat my condition as they deem appropriate through chiropractic, physiotherapy, and other supportive measures as explained to me.

Signature of person receiving care: ______________________ Date ______________
Guardian's signature of person receiving care: ______________________ Date ______________