WELCOME TO WEBER CHIROPRACTIC OFFICE, S.C.

Patient Name _____ Date _____

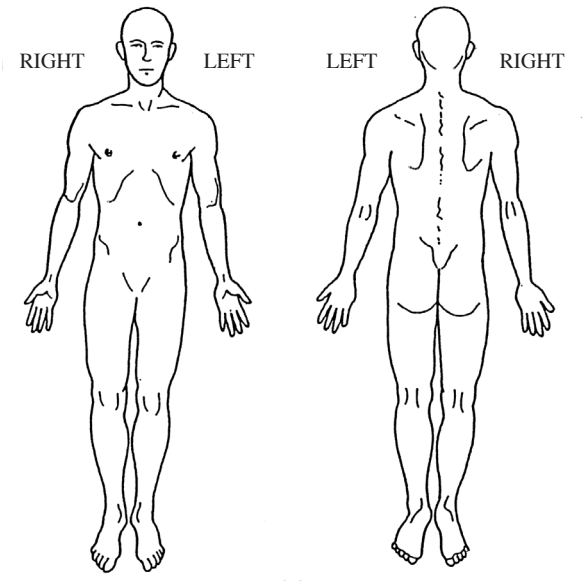
Dear Patient: Thank you for choosing our office for your health care. Please complete this background information. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Our professional concern is just two things, YOUR HEALTH & OUR REPUTATION.

LIST THE PROBLEMS THAT BROUGHT YOU TO VISIT OUR OFFICE AND WHEN THEY STARTED.

	Problem	**Date Started or How Long**
1.	_____	_____
2.	_____	_____
3.	_____	_____

WHICH ACTIVITY DOES YOUR PAIN LIMIT? ____ Sitting ____ Standing ____ Walking ____ Sleeping ____ Riding

PLEASE TELL US WHERE YOU HURT. Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend arrow as far as the pain travels. Use the appropriate symbol(s) listed below.



Ache >>>>
>>>>

Burning X X X X
X X X X

Stabbing / / / /
/ / / /

Pins and Needles o o o o
o o o o

Numbness = = = =
= = = =

Throbbing ~~~~
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INSTUCTIONS: Please put a mark on the line that best describes the question being asked

1. What is your pain RIGHT NOW?
no pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?
no pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level AT ITS BEST?
no pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level AT ITS WORST?
no pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

How much of the time do you have pain?
_____ 0-25% of time _____ 25-50% of time _____ 50-75% of time _____ 75-100% of time

Does your pain get worse at night? ____ Yes ____ No

Is this problem related to an accident? ____ Yes ____ No

If yes, _____ auto ____ work ____ slip/fall ____other - explain _____
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HEALTH HISTORY

Mark those conditions you have or have had and explain if needed.

	Yes	Explanation
Headaches / Migraine	_____	_____
High / Low blood pressure	_____	_____
Chest pain / Heart problems	_____	_____
Lung problems	_____	_____
Stomach problems / acid-reflux	_____	_____
Bowel problems / diarrhea / constipation	_____	_____
Bladder, kidney, prostate problems	_____	_____
Throat, swallowing problems	_____	_____
Nerves, anxiety, depression	_____	_____
Diabetes	_____	_____
Cancer	_____	_____
Weight loss / gain over 10#	_____	_____
Allergies (List All)	_____	_____
Arthritis/Joint Replacement	_____	_____
Dizziness, balance problems, vertigo	_____	_____
Facial pain, sinus problems, jaw pain	_____	_____
Liver/Hepatitis/Gallbladder	_____	_____

Is there anything else you feel the doctor should know? _____

Tobacco use never quit - when _____ Presently for _____ years

Alcohol use never frequency _____ / day _____ / week _____ / month

Family Medical History

	Age Now / At Death
Mother	_____/_____
Father	_____/_____
Brother(s)	_____/_____
Sister(s)	_____/_____
Grandmother(s)	_____/_____
Grandfather(s)	_____/_____

Disease in Family

Arthritis	Heart Disease	Cancer	Diabetes	Mental Decline	Multiple Sclerosis

List all surgeries you have had and the date you had them or how long ago. _____ none

1. _____ 2. _____

3. _____ 4. _____

List all medications and dosages you are taking. _____ none.

1. _____ 2. _____

3. _____ 4. _____

STATEMENT OF POLICY AND CONSENT TO TREAT

I state that the information is correct and reflects the extent of my current health status. I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give the authority for these procedures to be performed.

Patient's / Guardian's Signature _____ Date _____