CENTRE CHIROPRATIQUE LYON 1

Name: _____ Date: _____

Address: _____

Date of Birth: _____ Employer: _____

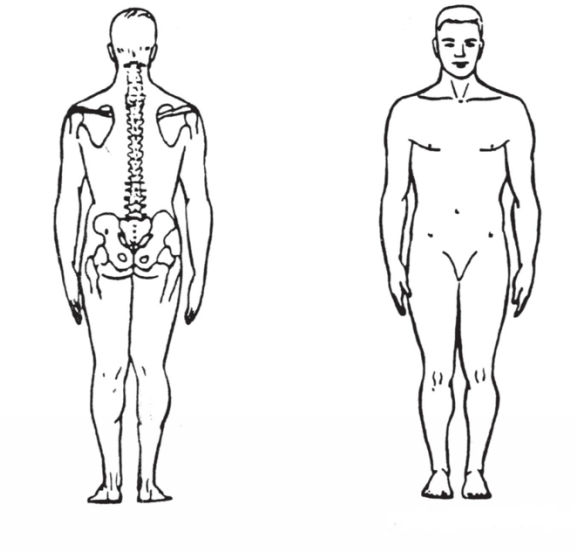
Cell Phone Number: _____ Home Phone Number: _____

Email: _____ Ages of children: _____

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Referred to our clinic by: _____

If you are in pain, please mark the exact location on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant on & off …



MAJOR COMPLAINT:

(Please describe only your major problem)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How did this condition develop? (What caused it? How did it start?) _____

_____

_____

_____

When was the first time you were aware of this problem? _____

Have you ever had this problem before? If yes, please explain: ☐ yes ☐ no

_____

On a scale from 0 to 10, where would you rate your pain? _____

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Are there any activities that worsen this condition? _____

_____

Is there anything that improves the pain? _____

_____

Has this problem been getting better, worse or the same? _____

Have you ever received any treatment for this condition? _____

Have you ever been in an automobile accident? _____

Any accidents / falls? □ yes □ no

Do you have any other symptoms? (if yes, please describe) _____

_____

Any fractures? (if yes, please describe) _____

Any surgery? (if yes, please describe) _____

Drugs you take now: □ Insulin □ Pain Killers □ Antidepressants □ Muscle Relaxers

□ Birth Control Pills □ Blood thinners □ Other (please list)

_____

Do you have any allergies? (if yes, please describe)_____

Any particular diet? (vegetarian, vegan) _____

Any: □ tobacco (____ cigarettes/day) □ alcohol (____ glasses/week)

Do you have any hobbies, or do any physical activity? _____

_____

Doctor's Notes:

_____

_____

_____

_____

_____

_____

_____

_____