# McKolosky Chiropractic

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|---|---|
| Patient Name: _____ | Home Phone: _____ |
| Address: _____ | Cell Phone: _____ |
| Date of Birth: _____ | Would you like text Reminders for appts? Y N |
| Height: _____ft_____inches | Email: _____ |
| Weight: _____lbs | Work Phone: _____ |
| Marital Status: M S W D | Employer: _____ |
| Referred By? : _____ | Occupation: _____ |
| Have you had xrays recently? Y N | Emergency Contact : _____ |
| If yes, Where?_____ | Relationship:_____ Phone#:_____ |

**Chief Complaint**: _____

**When did this condition begin?** _____

**Has it ever occurred before? Y N** If yes, when? _____

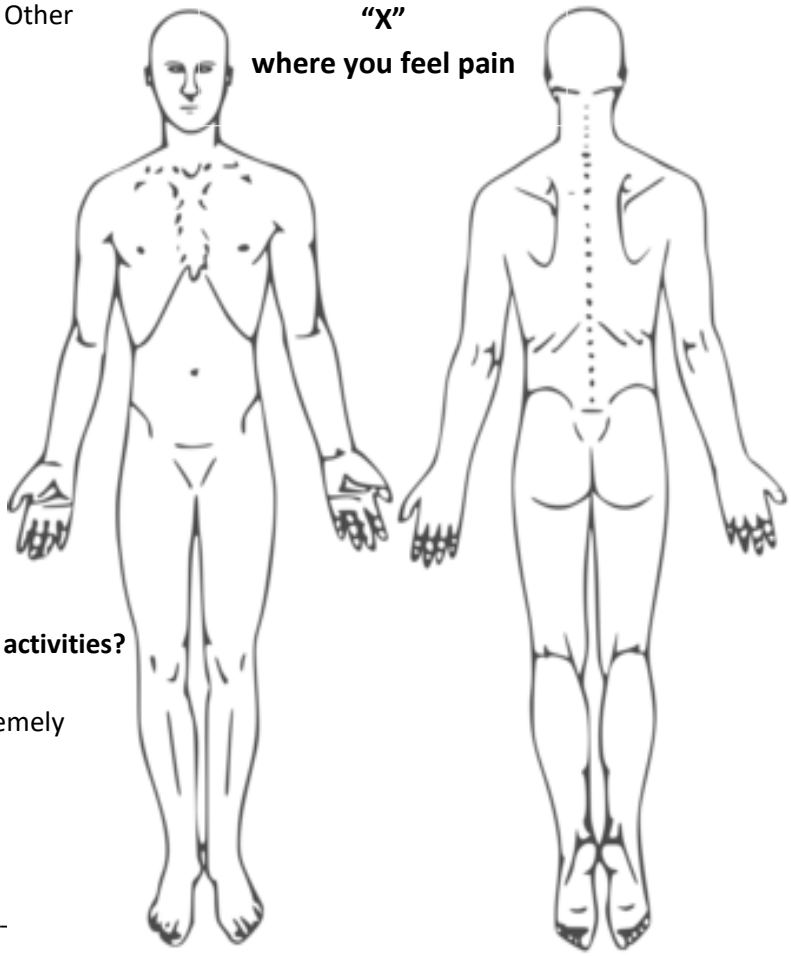
**Briefly describe your symptoms**: _____

**How did your symptoms start?** _____

**Is this Condition**: ☐ Auto Related ☐ Job Related ☐ Home Injury

☐ Slip or Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause ☐ Other

**Mark with an "X" where you feel pain**



**Average Pain Intensity**: (0 = no pain 10 = worst pain)

**At Rest**: 0 1 2 3 4 5 6 7 8 9 10

**During Activity**: 0 1 2 3 4 5 6 7 8 9 10

**How often do you experience symptoms?**

☐ Constantly (76-100% of the time)

☐ Frequently (51-75%)

☐ Occasionally (26-50%)

☐ Intermittently (0-25%)

**How much have your symptoms interfered with your usual daily activities?**

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No

If yes, who? _____

| Please list any medications you are currently taking and WHAT FOR… | ☐ Not currently prescribed any medication |
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**Allergic to any medication (s)?:**_____

**Smoking Status**

☐ Current every day smoker
☐ Current some day smoker
☐ Former Smoker
☐ Never smoker

**Use**

☐ Tobacco
☐ Alcohol
☐ Coffee

**DISEASE/CONDITION** (Please circle the appropriate answer)

| | | | |
|---|---|---|---|
| Arthritis | Self | Mother | Father |
| Osteoarthritis | Self | Mother | Father |
| Osteoporosis | Self | Mother | Father |
| Rheumatoid Arthritis | Self | Mother | Father |
| Fibromyalgia | Self | Mother | Father |
| Asthma | Self | Mother | Father |
| Heart Disease | Self | Mother | Father |
| High Blood Pressure | Self | Mother | Father |
| Thyroid disease | Self | Mother | Father |
| Diabetes | Self | Mother | Father |
| Kidney Disease | Self | Mother | Father |
| Autoimmune | Self | Mother | Father |
| Cancer | Self | Mother | Father |
| Other | Self | Mother | Father |

| Please list any major surgeries below ****Include any electronic devices implanted**** | Date |
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