

ORR CHIROPRACTIC CENTER WELCOMES YOU

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GENERAL INFORMATION

Patient Name: _____ Date: _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Cell Phone: _____
Date of Birth: _____ E-Mail: _____
Driver's License # _____ Social Security # _____
What other professionals have you seen for this
condition? DC ___ MD ___ PT ___
Past Chiropractic Care? Yes No
When? _____
Message ___ Orthopedist ___ Accupuncture ___
When? _____

PERSONAL INFORMATION

Marital: Single Married Divorced Widow
Spouse's Name: _____
Names & Ages of Your Children
name: _____ age: _____
name: _____ age: _____
name: _____ age: _____
Your Age: _____
Sex: Male Female

WORK INFORMATION

Occupation: _____
Employer: _____
Work Phone: _____

INSURANCE INFORMATION

Insured Name: _____
Insured SS#: _____
Insured Date of Birth: _____
Insurance Co: _____

Who may we thank for referring you to our office? _____

Who is responsible for your bill? _____ Please check the best choice which applies
You and your: ___ spouse ___ worker's comp ___ auto ins. ___ medicare ___ health ins.

At Orr Chiropractic Center we are a wellness center where we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us detailed information of the specific stresses past and present that you have faced and will allow us to better assess the challenges to your health potential. Thank you for allowing us the opportunity to improve the quality of your life.

HEALTH HABITS

smoking packs/day _____
drinking alcohol/day _____
coffee cups/day _____
water glasses/day _____
pop cans/day _____
sleep hours/night _____

Please check and fill in the appropriate boxes
Exercise: ___ none ___ moderate ___ daily
Type: _____
Do you take vitamins or minerals? Yes No
Please list _____
Which best describes your stress level?
None Minimal Moderate Tremendous

FAMILY HISTORY

Please circle all that apply

MOTHER diabetes heart backproblems headaches

FATHER diabetes heart backproblems headaches

BROTHER, # of ___ diabetes heart backproblems headaches

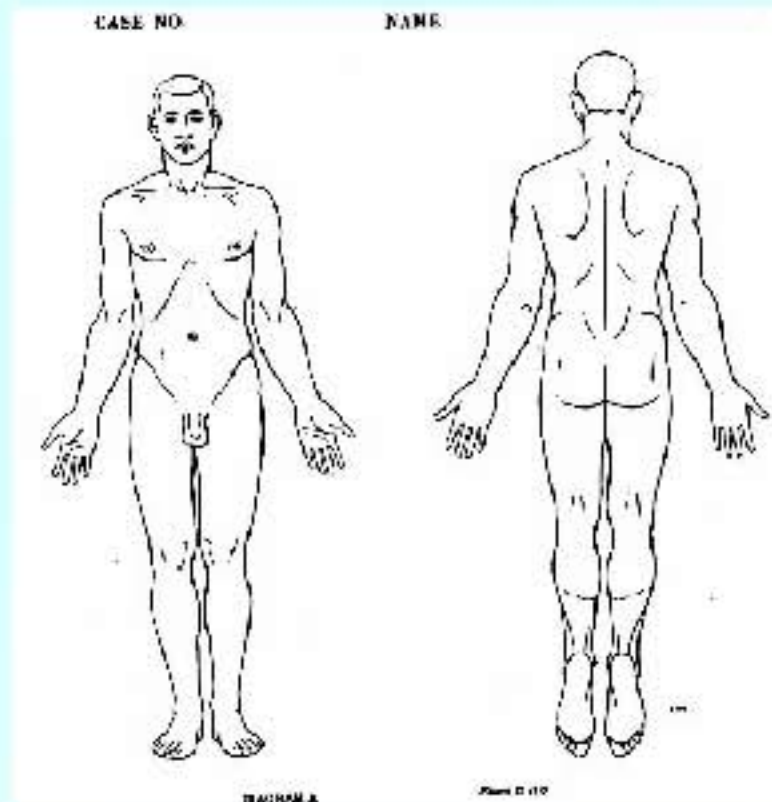
SISTER, # of ___ diabetes heart backproblems headaches

OPERATIONS & PROCEDURES

Please list all of the operations, procedures, broken bones, fractures, dislocated joints and spinal taps you have had over the years: _____

Using the symbols listed, mark on the drawings the areas on your body where you feel the described sensations:

- Numbness ===
- Dull Ache 000
- Hot Burning xxx
- Sharp Sensation //
- Pins and Needles +++
- Stiffness ***
- Weakness ^^^



Please list your 3 most significant traumas, this includes emotional, physical or chemical.

PLEASE FOLLOW THESE EASY INSTRUCTIONS TO FILL IN THE BOX BELOW

*In the Condition box, list your unwanted health conditions on the line after 1, 2, 3, 4 and 5

*In the Pain Level box, fill in your pain number for each condition on a scale of 1 - 10,

1 = no pain and 10 = most intense pain ever felt

*In the Time Frame box, fill in the length of time since you first noticed the problem.

*In the Frequency box, please write

C if Constant, F if Frequent, O if Occasional and I if Intermittent

*And finally, answer **yes** or **no** to the question "Is the problem worsening?"

| CONDITION | PAIN LEVEL | TIME FRAME | FREQUENCY | WORSENING? |
|---------------------------|------------|-----------------|-----------|------------|
| example: <i>heartburn</i> | <i>4</i> | <i>3 months</i> | <i>F</i> | <i>yes</i> |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

Explain **WHEN** and **HOW** your main complaint happened or began _____

Is this condition interfering with your: work __ leisure __ sleep __ sports/exercise __ positive mental attitude __ other __

Since your symptoms began have you noticed a change in: (please circle all that apply)

bowel function bladder function sexual function

What makes your condition **BETTER?** (please circle all that apply)

Ice Heat Rest Mid-day Stretching Exercise Walking Sitting Standing Nothing Morning

Evening Other _____

What makes your condition **WORSE?** (please circle all that apply)

Evening Other _____

How long has it been since your **REALLY** felt good?? _____

What do **YOU** believe is wrong with you?? _____

| General Symptoms | Constantly/ Frequently | Sometimes/ Occasionally |
|-----------------------------|---------------------------|----------------------------|
| allergies | | |
| bronchitis | | |
| convulsions | | |
| dizziness/fainting | | |
| depression/moodiness | | |
| fatigue | | |
| headache | | |
| loss or difficulty sleeping | | |
| weight change (+/-) | | |
| nervousness | | |
| night sweats | | |
| numbness in arms/legs/hands | | |
| pain in arms/legs/hands | | |
| crave sweets/salts | | |
| cold/tingling extremities | | |

| Eye/Ear/Nose/Throat | Constantly/ Frequently | Sometimes/ Occasionally |
|----------------------------|---------------------------|----------------------------|
| mouth sores | | |
| earache | | |
| ear ringing | | |
| enlarged thyroid/goiter | | |
| frequent colds | | |
| hoarseness | | |
| nasal obstruction | | |
| absence of taste | | |
| nose bleeds | | |
| absence of smell | | |
| vision trouble | | |
| sinusitis | | |
| sore throat/tonsillitis | | |
| dental problems | | |
| hearing difficulties | | |
| deafness | | |

| Gastro-Intestinal | Constantly/ Frequently | Sometimes/ Occasionally |
|----------------------------|---------------------------|----------------------------|
| belching or gas | | |
| constipation | | |
| diarrhea | | |
| hemorrhoids | | |
| frequent nausea | | |
| abdominal pain | | |
| appetite increase/decrease | | |
| vomiting | | |
| excessive thirst | | |
| heartburn/indigestion | | |
| black/bloody stool | | |
| ulcers | | |
| difficult chewing/clicking | | |
| acid reflux | | |

| Respiratory | Constantly/ Frequently | Sometimes/ Occasionally |
|---------------------|---------------------------|----------------------------|
| chest pain | | |
| asthma | | |
| chronic cough | | |
| difficult breathing | | |

| Muscles & Joints | Constantly/ Frequently | Sometimes/ Occasionally |
|-----------------------------|---------------------------|----------------------------|
| foot trouble | | |
| walking difficulty | | |
| hernia | | |
| tremors/twitching | | |
| joint pain with stiffness | | |
| cold/heat intolerance | | |

| Skin or Allergies | Constantly/ Frequently | Sometimes/ Occasionally |
|--------------------------|---------------------------|----------------------------|
| boils or skin eruptions | | |
| bruising easily | | |
| dryness/eczema | | |
| hives or itching | | |

| Cardio-Vascular | Constantly/ Frequently | Sometimes/ Occasionally |
|---------------------------|---------------------------|----------------------------|
| | high blood pressure | |
| low blood pressure | | |
| pain over heart | | |
| poor circulation | | |
| rapid heart | | |
| slow heart | | |
| stroke | | |
| swelling ankles/feet/legs | | |
| varicose veins | | |
| pacemaker | | |

Please use the scale for the following activities of daily living:
 U= unable L= limited N= normal

| | |
|---|------------------|
| _____ walking | _____ lifting |
| _____ standing | _____ running |
| _____ sitting | _____ sleeping |
| _____ housework | _____ exercising |
| _____ bending | |
| _____ stair climbing | |
| _____ stooping/kneeling | |
| _____ driving/getting in & out of a car | |
| _____ personal grooming | |

| Genito-Urinary | Constantly/ Frequently | Sometimes/ Occasionally |
|----------------------------|---------------------------|----------------------------|
| | bed wetting | |
| blood in urine | | |
| frequent/painful urination | | |
| inability to control urine | | |
| kidney infection | | |
| prostate trouble | | |
| infertility | | |
| sexual dysfunction | | |

Circle all that apply to you or have applied to you at any time in your life:

- _____ appendicitis
- _____ epilepsy
- _____ polio
- _____ alcoholism
- _____ osteoporosis
- _____ anemia
- _____ rheumatic fever
- _____ chicken pox
- _____ eczema
- _____ scoliosis
- _____ heart disease
- _____ pneumonia
- _____ pleurisy
- _____ whooping cough
- _____ multiple sclerosis
- _____ arthritis
- _____ mumps
- _____ HIV positive
- _____ cancer
- _____ spinal disc disease
- _____ measles
- _____ influenza
- _____ tuberculosis
- _____ venereal disease
- _____ goiter(thyroid)
- _____ mental disorder
- _____ diabetes

| For Women Only | Constantly/ Frequently | Sometimes/ Occasionally |
|-----------------------|---------------------------|----------------------------|
| | excessive flow | |
| hot flashes | | |
| irregular cycle | | |
| miscarriage | | |
| painful periods | | |
| breast pain | | |
| breast lumps | | |
| vaginal discharge | | |

Have past pregnancies been normal? yes no

Age of 1st menses _____

Date of last menses _____

Pregnant at this time? yes no