Associated Chiropractics ♦ Dr. Kelsey Roberts ♦ 54 Dwight Ave. Clinton, NY 13323. ♦ (315)-853-6225 ♦ AssociatedChiropractics.com

HEALTH REPORT

Please fill in ALL portions of the form.

Previous Chiropractic Care? ☐ Yes ☐ No

Patient Health History: Please check all that apply:

☐ Anticoagulant Use	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Stroke/TIAs
☐ Heart Complications	☐ Lung Complications	☐ Pacemaker	☐ Headaches	☐ Memory Loss
☐ Thyroid Disease	☐ Blood Disorders	☐ Bowel/Bladder Issues	☐ Nausea	☐ Regular Anti-inflammatory Use
☐ Arthritis	☐ Scoliosis	☐ Broken Bones	☐ Trauma/MVA	☐ Joint Replacements

Comments:____

____

Height: ______Feet______Inches Weight: _______________lbs

Medications: Please list any medications currently being taken along with dose and frequency:

Medication:	*Dose/Frequency:*
______________________	______________________
______________________	______________________
______________________	______________________

Previous Surgeries/Procedures: Please list any past surgeries/procedures with approximate date:

Surgery/Procedure:	*Date:*
______________________	______________________
______________________	______________________
______________________	______________________

Previous Diagnostic Imaging: ☐ X-Ray ☐ MRI ☐ CT ☐ Other

Comments:____

Allergies: Please list any allergies:

____

____

Social History: Please indicate the following:

Cigarette/Tobacco Use:	☐ Yes	☐ Never	☐ Previous Use	
Drug Use:	☐ Yes	☐ Never	☐ Previous Use	
Alcohol Use:	☐ Light	☐ Moderate	☐ Heavy	☐ None
Exercise Level:	☐ Light	☐ Moderate	☐ Strenuous	☐ None
Hours of Sleep/Night:	☐ 0-3 hours	☐ 4-7 hours	☐ 7-10 hours	☐ 10+ hours

Pregnancy History: Currently Pregnant? ☐ Yes ☐ No Number of children:__________

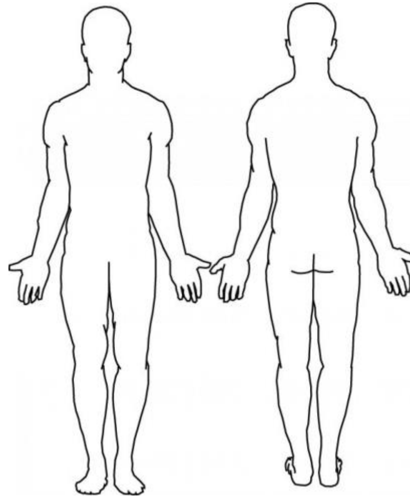
Family Health: Please check if any blood relative has had any of the following:

☐ Cancer	☐ Epilepsy/Seizure	☐ Lung Disease	☐ Stroke/TIAs
☐ Aneurysm	☐ Headaches	☐ Heart Disease	☐ Arthritis
☐ Diabetes	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ Thyroid Issues

Comments:____

____

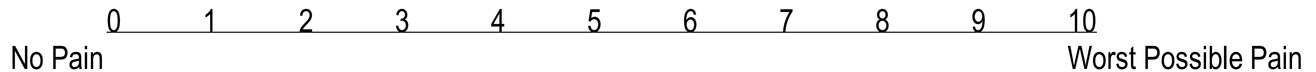
Chief Complaint # 1 : Mark symptomatic area(s):



Symptoms are:

☐ Achy	☐ Burning	☐ Pins and Needles	☐ Sharp with motion	
☐ Numb	☐ Shooting/Radiating	☐ Stiff	☐ Shooting with motion	
☐ Sharp	☐ Dull	☐ Cramping	☐ Stabbing with motion	☐ Other

Please indicate symptom intensity (the majority of the time):



Percentage of the day with symptoms:

☐ 0-10% ☐ 20-30% ☐ 40-50% ☐ 60-70% ☐ 80-90% ☐ 100%

Aggravating Factors:

☐ Bending	☐ Twisting	☐ Walking	☐ Reaching	☐ Driving
☐ Standing	☐ Turning	☐ Running	☐ Squatting	☐ Household activities
☐ Sitting	☐ Changing positions	☐ Lifting	☐ Coughing	☐ Exercising
☐ Sleeping	☐ Heat	☐ Ice	☐ Sneezing	☐ Laying Down
				☐ Other

Alleviating Factors:

☐ Ice	☐ Stretching	☐ Exercise	☐ Laying Down	☐ Chiropractic Care
☐ Heat	☐ Sleeping	☐ NSAIDs/Pain Relievers	☐ Massage	☐ Nothing
☐ Muscle Gels/Lotions	☐ Standing	☐ Sitting	☐ Acupuncture	☐ Other

Onset:

☐ Suddenly ☐Gradually

When did symptoms begin?:____

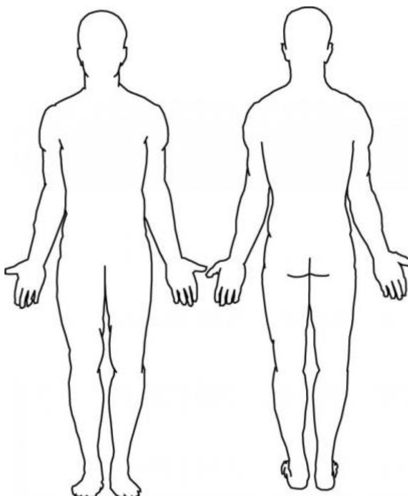
How did symptoms begin?:____

____

Have you received previous treatment for this complaint? ☐ Yes ☐ No

Comment:____

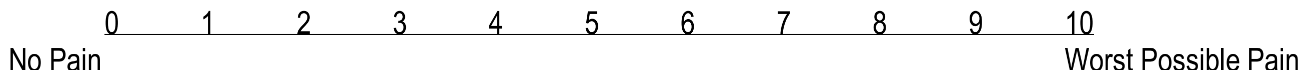
Chief Complaint # 2 : Mark symptomatic area(s):



Symptoms are:

☐ Achy	☐ Burning	☐ Pins and Needles	☐ Sharp with motion	
☐ Numb	☐ Shooting/Radiating	☐ Stiff	☐ Shooting with motion	
☐ Sharp	☐ Dull	☐ Cramping	☐ Stabbing with motion	☐ Other

Please indicate symptom intensity (the majority of the time):



Percentage of the day with symptoms:

☐ 0-10% ☐ 20-30% ☐ 40-50% ☐ 60-70% ☐ 80-90% ☐ 100%

Aggravating Factors:

☐ Bending	☐ Twisting	☐ Walking	☐ Reaching	☐ Driving
☐ Standing	☐ Turning	☐ Running	☐ Squatting	☐ Household activities
☐ Sitting	☐ Changing positions	☐ Lifting	☐ Coughing	☐ Exercising
☐ Sleeping	☐ Heat	☐ Ice	☐ Sneezing	☐ Laying Down
				☐ Other

Alleviating Factors:

☐ Ice	☐ Stretching	☐ Exercise	☐ Laying Down	☐ Chiropractic Care
☐ Heat	☐ Sleeping	☐ NSAIDs/Pain Relievers	☐ Massage	☐ Nothing
☐ Muscle Gels/Lotions	☐ Standing	☐ Sitting	☐ Acupuncture	☐ Other

Onset:

☐ Suddenly ☐Gradually

When did symptoms begin?:____________________________________

How did symptoms begin?:____________________________________

____

Have you received previous treatment for this complaint? ☐ Yes ☐ No

Comment:____

Chief Complaint # 3 : Mark symptomatic area(s):

Symptoms are:

☐ Achy	☐ Burning	☐ Pins and Needles	☐ Sharp with motion	
☐ Numb	☐ Shooting/Radiating	☐ Stiff	☐ Shooting with motion	
☐ Sharp	☐ Dull	☐ Cramping	☐ Stabbing with motion	☐ Other

Please indicate symptom intensity (the majority of the time):

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Possible Pain

Percentage of the day with symptoms:

☐ 0-10% ☐ 20-30% ☐ 40-50% ☐ 60-70% ☐ 80-90% ☐ 100%

Aggravating Factors:

☐ Bending	☐ Twisting	☐ Walking	☐ Reaching	☐ Driving
☐ Standing	☐ Turning	☐ Running	☐ Squatting	☐ Household activities
☐ Sitting	☐ Changing positions	☐ Lifting	☐ Coughing	☐ Exercising
☐ Sleeping	☐ Heat	☐ Ice	☐ Sneezing	☐ Laying Down
				☐ Other

Alleviating Factors:

☐ Ice	☐ Stretching	☐ Exercise	☐ Laying Down	☐ Chiropractic Care
☐ Heat	☐ Sleeping	☐ NSAIDs/Pain Relievers	☐ Massage	☐ Nothing
☐ Muscle Gels/Lotions	☐ Standing	☐ Sitting	☐ Acupuncture	☐ Other

Onset:

☐ Suddenly ☐Gradually

When did symptoms begin?:____
How did symptoms begin?:____

Have you received previous treatment for this complaint? ☐ Yes ☐ No
Comment:____