TODAY'S DATE: ____/_____/_____

BLUME healing center

PATIENT INFORMATION

Name: (Last)_____ (First)_____ (MI)_____ **Nickname**:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone number: Home:(_____)_____ Work:(_____)_____ Cell:(_____)_____

E-mail Address: _____ May we leave messages at the above numbers ❑ Yes ❑ No

Birth Date:_____/_____/_____ **Sex**: ❑ Male ❑ Female Social Security number:_____-_____-_____

Civil Status: ❑ Married ❑ Single ❑ Divorced **Employment**: ❑Full ❑Part ❑Retired ❑Unemployed ❑Student

Occupation:_____ Employer's Name:_____

CURRENT SYMPTOMS/COMPLAINTS

Briefly describe the reason for today's visit: _____

Have you had a similar condition in the past? ❑ yes ❑ no

Are your complaints related to a(n): ❑ Auto Accident ❑ Work Injury ❑ Sports Injury When?:_____

Have you been treated by anyone else for this condition? ❑ yes ❑ no If yes, what treatment have you received?

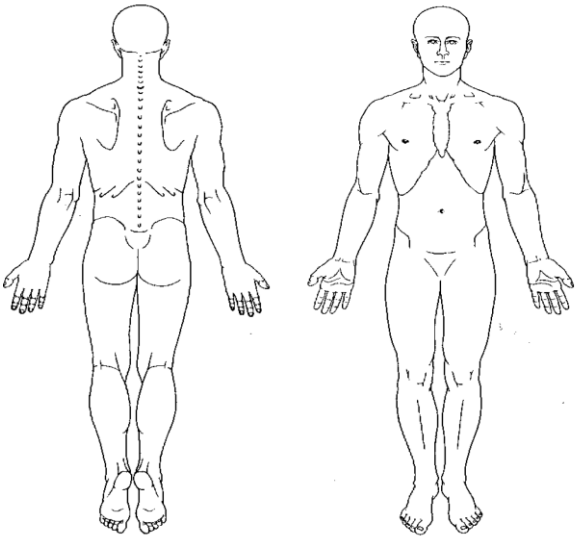
Type of care received: ❑ Physical Therapy ❑ Massage Therapy ❑ Medication ❑ Other:_____

_____

Have you ever seen a chiropractor before? ❑ yes ❑ no If yes, why? _____

PAIN RATING

Please indicate on the drawing the location of your pain or discomfort.



Please rate the severity of your complaint(s) **over the last 24 hrs** (10 = worst pain):

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

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

Currently: 0 1 2 3 4 5 6 7 8 9 10

What makes the symptom *better*? (mark all that apply):	**What makes the symptom *worse*?** (mark all that apply):		**Describe the symptom:** (mark all that apply):
❑ rest	❑ bending head	❑ turning head	❑ sharp
❑ ice	❑ bending at the waist	❑ standing	❑ dull
❑ heat	❑ twisting at waist	❑ sitting	❑ achy
❑ stretching	❑ getting up from sitting	❑ lifting	❑ burning
❑ exercise	❑ any movement	❑ driving	❑ throbbing
❑ massage	❑ walking	❑ running	❑ stabbing
❑ pain medication	❑ nothing		❑ deep
❑ nothing			❑ shooting

REVIEW OF SYSTEMS

Please mark all conditions/symptoms listed below which you now have or have had previously:

Cardiovascular
- ❑ Heart surgeries
- ❑ Congestive heart failure
- ❑ Hypertension
- ❑ Heart attacks
- ❑ Heart disease/problems
- ❑ Angina/chest pain
- ❑ Irregular heartbeat

Neurological
- ❑ One-sided decreased feeling in the face or body
- ❑ One-sided weakness of face or body
- ❑ History of seizures
- ❑ Visual changes/loss of vision
- ❑ Headaches
- ❑ Vertigo
- ❑ Memory loss
- ❑ Strokes

Gastroenterological
- ❑ Nausea
- ❑ Difficulty swallowing
- ❑ Ulcerative disease
- ❑ Frequent abdominal pain
- ❑ Hiatal hernia
- ❑ Constipation
- ❑ Irritable bowel/colitis
- ❑ Hepatitis or liver disease
- ❑ Bowel incontinence
- ❑ Gastroesophageal reflux/heartburn

Musculoskeletal
- ❑ Rheumatoid arthritis
- ❑ Osteoarthritis
- ❑ Gout
- ❑ Broken bones
- ❑ Spinal fracture
- ❑ Spinal surgery
- ❑ Arthritis (unknown type)
- ❑ Metal implants
- ❑ Scoliosis
- ❑ Joint surgery

SURGERIES

List any major surgeries you have had and the date:

_____ _____

_____ _____

_____ _____

MEDICATIONS

List any medications you currently take and the reason:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HEALTH HISTORY

Indicate if you have a family history of these conditions and the family relationship to yourself:

Condition	Relationship (father, mother, etc.)	Condition	Relationship (father, mother, etc.)
❑ Cardiac Disease:		❑ Neurological diseases	
❑ Stroke/TIA::		❑ Cancer	
❑ Headaches:		❑ Diabetes	
❑ Other:		❑ Adopted/Unknown	

SOCIAL/OCCUPATIONAL HISTORY

Tobacco	Alcohol	Caffeinated Beverages
❑ Non-smoker ❑ Previous smoker (year quit_____) ❑ Current smoker (Packs/day ____)	❑ Never ❑ Occasional Drinks/week _____	❑ Coffee (Cups per day _____) ❑ Tea (Cups per day _____) ❑ Soda Pop (Cans per day ____)

Job description: _____

Routine exercise: _____