Parkway Family Chiropractic

Dr. Lisa L. Boeser

ABOUT THE PATIENT: Today's Date_____

Name: _____ Date of Birth_____

Address: _____

City: _____State: _____Zip:_____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Occupation: _____

Whom may I thank for referring you to Parkway Chiropractic?_____

EXPERIENCE WITH CHIROPRACTIC:

Have you been adjusted by a chiropractor before?_____ Doctor's Name_____

Approximate date of last visit?_____

What was the reason for those visits?_____

REASON FOR SEEKING CARE:

If you have no symptoms and are here for wellness care, please check here: □ I wish to have wellness services.

What are your current health concerns? _____

How did this problem begin (eg. fall, lifting, etc.)? _____

How long have you had this condition? (Date of Onset)_____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working, exercising, driving or sleeping?

(0= no effect and 10= no activity is possible) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

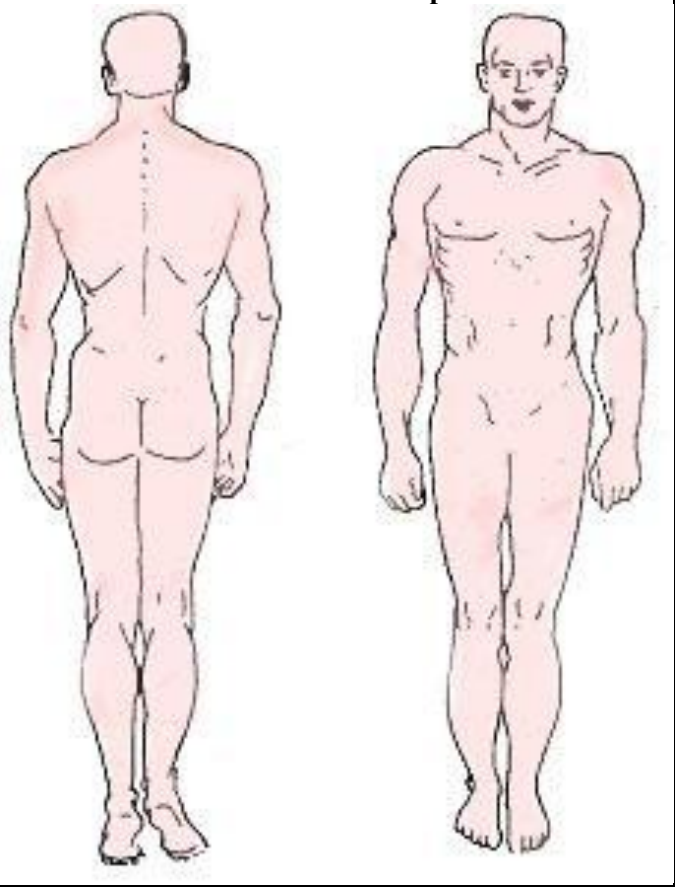
What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

***Please Check* ✓all the conditions that you have experienced in the last 6 months, even if they do not seem related to chiropractic or your current problem.**

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Dizziness	❑	❑
Sinus Problems	❑	❑
Allergies	❑	❑
Ear Infections	❑	❑
Low Energy	❑	❑
Sleep Issues	❑	❑
Neck Pain	❑	❑
Radiating Arm Pain	❑	❑
Hand Numbness	❑	❑
Asthma	❑	❑
Heart Conditions	❑	❑
Thyroid Problems	❑	❑
Upper Back Pain	❑	❑
Heartburn	❑	❑
Indigestion	❑	❑
Frequent Colds	❑	❑
Gallbladder Issues	❑	❑
Skin Conditions	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Gas Pains	❑	❑
Low Back Pain	❑	❑
Leg Pain	❑	❑
Numbness in Legs	❑	❑
PMS	❑	❑
Bladder Problems	❑	❑
Plantar Fascitis	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Blood In Stool	❑	❑
Yeast Infections	❑	❑
Diabetes	❑	❑
Other	❑	❑

Circle the areas where you have any problems. Please also describe these problems.



Below, please describe any other health information you feel might be important to your care.

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

CURRENT MEDICATIONS:
Please provide a list of medications you currently take:

_____
_____
_____

SUPPLEMENTS:
Please provide a list of supplements you currently take:

_____
_____
_____

WELLNESS PROFILE:
Your care at Parkway Family Chiropractic can go far beyond symptom relief. Dr. Lisa can educate you on how to improve your overall health and well-being. Please check any of the following goals you are interested in:

__More Energy	__Better Sleep
__Weight Loss	__Better Concentration
__Better Overall Health	__Improved Immune System Function
__More Balanced Posture	__Improve Nutrition
__Reduce Medications	__Try Quality Vitamin Supplements
__Other_____	

GOALS FOR YOUR CARE:
How would you currently rate your overall health?

Poor □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 Excellent

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the actual cause of pain and others for correction of whatever is malfunctioning in their body. Your needs and desires will be taken into account when recommending your care program. Please select the type of care desired:

__ **Relief Care**: Symptomatic relief of pain or discomfort
__ **Corrective Care:** Correcting and relieving the cause of the problem and the symptom
__ **Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health possible (This includes chiropractic care & lifestyle (nutrition and exercise) guidance)

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever has a change in health status.

Signature_____Date_____