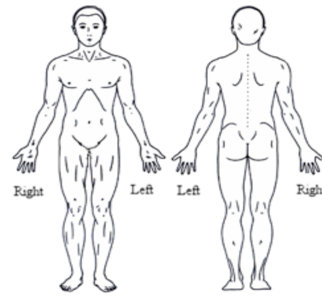
5

Circle below the severity of your pain on a scale of 0 to 10
(No Pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe Pain)
What makes your condition better? ________________________
What makes your condition worse?________________________
Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Activity
Activities/movements that are painful to perform:
❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down
❑ Driving ❑ Reading ❑ Getting Up ❑ Other ____________
What time of day is your pain worst? ____________________



6

HEALTH HISTORY

What other treatments have you had for this condition?
❑ Chiropractic ❑ Physical Therapy ❑ Medication ❑ Surgery ❑ Orthopedic ❑ Neurologist
Name of other doctors who have treated you for this condition______________________________
Describe the other doctor's treatment for your condition______________________________
Previous Chiropractic care? ❑ Yes ❑ No Date________________
List any medications you are taking & what they are treating:______________________________
____
Previous Surgeries______________________________
Vitamins/Herbs/ Minerals______________________________
Fractures______________________________
Females Are you Pregnant? ❑ Yes ❑ No Date of last PAP test ______________
Check any of the following conditions you have had:

General History
❑ Trauma
❑ Height or Weight change
❑ Fever/ chills
❑ Sweats
❑ Allergies
❑ Anemia
❑ Bleeding/bruising
❑ Fatigue/weakness

Your Family's History
❑ Diabetes
❑ Thyroid disease
❑ Tuberculosis
❑ Kidney disease
❑ High blood pressure
❑ Heart disease/stroke
❑ Musculoskeletal disease
❑Cancer
❑ Other _____

Gastrointestinal System
❑Nausea/vomiting
❑Vomiting blood
❑Peptic Ulcer
❑Indigestion/heartburn
❑Abdominal pain/swelling
❑Change in stool/color/etc
❑Diarrhea
❑Hernia
❑Hemorrhoids
❑Gallbladder disease
❑Liver disease
❑Pancreatitis
❑Alcohol Intake
_______Amount

Endocrine system
❑ Thyroid problem
❑ Diabetes
❑ Neck Surgery/irradiation

Eyes/Ears/Nose/Throat
❑Visual problems
❑Pain in eyes
❑Difficulty hearing/deaf
❑Ringing in ears
❑Ear Pain
❑Nosebleeds
❑ Sinus Infections
❑Difficulty swallowing
❑Enlarged painful/glands
❑Dental problems

Respiratory System
❑ Difficulty breathing
❑Cough
❑Coughing Blood
❑Wheezing/asthma
❑Tuberculosis/ exposure
❑Pneumonia/lung infection

Urinary System
❑Frequent urination
❑Pain on urination
❑Change in urine color
❑Difficulty starting stream
❑Difficulty in holding stream
❑Discharge
❑Urinary Tract Infection
❑Kidney disease
❑Pelvic Pain

Cardiovascular System
❑Short breath w/ activity
❑Chest pain
❑Palpitations
❑Fainting
❑Sudden calf pain w/ walking
❑Rheumatic fever
❑Pacemaker

Skin/Hair/Nails
❑Skin dryness/wetness
❑Rashes/itching/sores
❑Skin growths
❑Mole changes
❑Skin Cancer
❑Change in finger nails
❑Unusual skin lumps

Neurological System
❑Headches
❑Epileptic seizures
❑Head Trauma
❑Numbness/tingling
❑Fainting/ Dizzy

Breasts
❑Lumps/masses
❑Pain
❑ Change in shape

All Reviewed by Dr.________________________________

LIFESTYLE
❑ Smoking Packs/Day______________________
❑ Alcohol Drinks/Week____________________
❑ Coffee/Caffeine Drinks Cups/Day______________________
❑ High Stress Level Reason________________________

EXERCISE
❑ None
❑ Mild (1-2 times wk)
❑ Moderate (3-4 times wk)
❑ Heavy (5+ wk)

DIET-VITAMINS
Are you on a special diet?_________
Are you vegetarian______________
If yes, are you taking any supplements
____

Are you interested in?
Spinal Decompression ❑ Yes ❑ No
Personal Training Instruction ❑Yes ❑ No
Vitamins/Supplements ❑ Yes ❑ No
Weight Loss ❑ Yes ❑ No

AUTHORIZATION

Office policy is that payment is due at the time of service. This includes all co-pays, co-insurance, and deductibles. Insurance verification and authorization is not guarantee of payment. If I choose to utilize my insurance I give permission for Grant Babkow, D.C. to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. Should Grant Babkow, D.C. be out of network, I will complete an Out Of Network Agreement form and Assignment of Benefits form that will be sent to my insurance to direct them to make payments to Grant Babkow, D.C. and send them directly to Grant Babkow, D.C. I clearly understand that I am ultimately personally responsible to pay for all services rendered to me or my dependent.

X____ Date:__________________________