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Nystrom CHIROPRACTIC

# Welcome to Nystrom Chiropractic

Please tell us about yourself

**Name:** (Last)_____(First)_____(MI)___ **Male**____ **Female**____

**Home Address:** (st.)_____(city)_____(state)____ (zip)_____

**Home Phone Number:** (___) _____ **Cell Phone/ Pager:** (___) _____

**E-mail:** _____@_____

**Check here if you <u>DO NOT</u> want to be on our email list for our special events & newsletters:** _____

**Birthdate:**___/___/___ **Age**:_____ **Marital Status:** M / S / D / W

**Occupation:** _____ **Employer Name:**_____

**Work Phone Number:** (___) _____**Ext:**_____

**Emergency Contact:**_____**Phone Number:** (___)_____

**Person responsible for this account:** _____

**Please provide us with the name and phone number of the person who referred you to our office so that we may thank them for their referral with a free adjustment:**_____

**Phone number:**_____

**PLEASE READ AND SIGN BELOW**

I understand that all services rendered me are charged directly to me and I am personally responsible for payment at the time of service.

Responsible Party Signature_____ Date _____/_____/_____

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# Symptom Survey

Please circle all symptoms
you have EVER experienced

**General Symptoms:**

A) Nervousness B) Irritability C) Fatigue D) PMS
E) Depression F) Sleep Loss G) Tension H) Jaw Pain

**Head:**

A) Headache 1) Mild 2) Moderate 3) Severe
How often: (1 2 3 4 5 6) Per (Day Wk. Mo.)
Are they: 1) Sharp 2) Dull
Are they: 1) Constant 2) Intermittent
Where located: 1) Back of head 2) Temples
3) Forehead 4) Right side
5) Left side 6) Behind eyes
B) Light Headed C) Memory Loss D) Ringing in ears
E) Hearing Loss F) Blurred vision G) Loss of Balance
H) Double Vision I) Fainting J) Sensitivity to light

**Neck:**

A) Pain: 1) Left Side 2) Right Side 3) Both
Pain Level 1) Mild 2) Modrate 3) Severe
Pain Increased By: 1) Forward Movement
2) Background Movement
3) Rotate Left 4) Rotate Right
5) Bend Left 6) Bend Right
B) Stiffness C) Muscle Spasm D) Grind/Grating Sounds

**Shoulders:**

| | | | |
|---|---|---|---|
| A) Pain in joint: | 1) Left | 2) Right | 3) Both |
| B) Pain across shoulders | 1) Left | 2) Right | 3) Both |
| C)Limitation of movement | 1) Left | 2) Right | 3) Both |
| D) Tension | 1) Left | 2) Right | 3) Both |

**Arms:**

| | | | |
|---|---|---|---|
| A) Pain in upper arm | 1) Left | 2) Right | 3) Both |
| B) Pain in elbow | 1) Left | 2) Right | 3) Both |
| C) Pain in forearm | 1) Left | 2) Right | 3) Both |
| D) Pins and needles (arm) | 1) Left | 2) Right | 3) Both |
| E) Pins and needles(forear | 1) Left | 2) Right | 3) Both |
| F) Numbness in forearm | 1) Left | 2) Right | 3) Both |

**Hands:**

| | | | |
|---|---|---|---|
| A) Pain in wrist | 1) Left | 2) Right | 3) Both |
| B) Pain in hand | 1) Left | 2) Right | 3) Both |
| C) Pins and Needles | 1) Left | 2) Right | 3) Both |
| D) Numbness | 1) Left | 2) Right | 3) Both |

**Mid- Back:**

A) Pain 1) Left 2) Right 3) Both
Pain level: 1) Mild 2) Moderate 3) Severe
Pain Type: 1) sharp/stabbing 2)Dull Ache
B) Spasm 1) Left 2) Right 3) Both

**Chest**

| | | | |
|---|---|---|---|
| A) Deep chest pain: | 1) Left | 2) Right | 3) Both |
| Pain Level: | 1) Mild | 2) Moderate | 3) Severe |
| B) Pain around ribs: | 1) Left | 2) Right | 3) Both |
| C) Shortness of breath | | | |
| D) Irregular Heartbeat | | | |

**Abdominal Symptoms:**

A) Pain 1) Mild 2) Moderate 3) Severe
B) Nervous Stomach C) Nausea D) Gas
E) Constipation F) Diarrhea G) Heartburn
H) Menstual Cramps

**Low-Back**

| | | | |
|---|---|---|---|
| A) Upper low-back pain: | 1) Left | 2) Right | 3) Both |
| B) Lower low-back pain: | 1) Left | 2) Right | 3) Both |
| C) Sacro-illiac pain | 1) Left | 2) Right | 3) Both |
| D) Muscle Spasm | 1) Left | 2) Right | 3) Both |
| E) Low-back pain level | 1) Mild | 2) Moderate | 3) Severe |

**Hips and Legs:**

| | | | |
|---|---|---|---|
| A) Pain in buttocks: | 1) Left | 2) Right | 3) Both |
| Pain Level: | 1) Mild | 2) Moderate | 3) Severe |
| B) Pain in hip joint: | 1) Left | 2) Right | 3) Both |
| Pain Level: | 1) Mild | 2) Moderate | 3) Severe |
| C) Pain down leg: | 1) Left | 2) Right | 3) Both |
| Location: | 1) Left | 2) Back | 3) Side |
| D) Numbness down leg: | 1) Left | 2) Right | 3) Both |
| Location: | 1) Left | 2) Back | 3) Side |
| E) Pins & needles (leg) | 1) Left | 2) Right | 3) Both |
| Location: | 1) Left | 2) Back | 3) Side |
| F) Knee pain: | 1) Left | 2) Right | 3) Both |
| G) Leg Cramps | 1) Left | 2) Right | 3) Both |

**Feet:**

| | | | |
|---|---|---|---|
| A) Ankle pain | 1) Left | 2) Right | 3) Both |
| B) Swollen ankle | 1) Left | 2) Right | 3) Both |
| C) Foot pain | 1) Left | 2) Right | 3) Both |
| D) Numbness of feet | 1) Left | 2) Right | 3) Both |
| E) Swollen feet | 1) Left | 2) Right | 3) Both |
| F) Cramps | 1) Left | 2) Right | 3) Both |

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# Confidential Patient Case History

Patient Name:_____ Date:_____

Was condition related to employment?___No ___Yes Date of injury:_____

Was condition related to auto accident?___No ___Yes Date of injury:_____

## Check the Following Conditions You have Had

| | | | |
|---|---|---|---|
| __Cancer | __Stroke | __Hepatitis | __Measles |
| __Kidney Infection | __Goiter | __Polio | __Mumps |
| __Diabetes | __Anemia | __Ulcer | __Small Pox |
| __Heart Disease | __Pneumonia | __Alcoholism | __Chicken Pox |
| __High Blood Pressure | __Appendicitis | __Mental/emotional | __Tuberculosis |

## Surgeries/Hospitalizations:

_____Year_____

_____Year_____

_____Year_____

_____Year_____

## Injuries/Fractures/Dislocations:

_____Year_____

_____Year_____

_____Year_____

_____Year_____

## Lifestyle Habits:

Tobacco (Cigarettes/day)_____ Coffee (cups/day)_____ Sleep (hours/day)_____

Alcohol (drinks/day)_____ Tea (cups/day)_____ Soft drinks (cups/day) _____

Exercise: Type: _____ Frequency:_____

(1 Drink = 1.5 oz. liquor, 12 oz. beer, or 6 oz. wine)

## Current Work Status: (please circle)

Regular Duty Limited/Light Duty Date Began:_____

Lost Time (off work) Date Began: _____ Date resumed work: _____

## Family Health History:

| Relation | Name | Age | Health Problems |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Sister(s) | | | |
| Brother(s) | | | |

## Medications Taken Now: (prescription and nonprescription; include vitamins, supplements, etc.)

| Name of medication | Purpose | Dosage | How long taken? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you seen a chiropractor before?___Yes ___No
If yes, Dr's Name_____Date of Last Visit _____

Have you ever been in a motor vehicle accident before?
_____Past Year _____ Past five years _____ Over five years ____ Never

Date of last menstrual period: _____

## History of Chief Complaint:

What is your major complaint? _____

How long has this bothered you? _____

When and how did this begin? (accident, injury, etc.)

Have you had this or similar conditions in the past?____ Yes ___No
If yes, when _____

When is your pain most severe?
_____Morning ____Afternoon ____Evening ____Sleeping ____All the time

What activities make your condition worse? (please circle all that apply)
Standing Walking Sitting Lying Bending Lifting Twisting Coughing
Other: _____

What activities make your condition better? (please circle all that apply)
Medication Exercise Lying Standing Walking Bending Sitting
Other:_____

List the doctors, therapist, etc. you have seen for this condition, dates, diagnostic tests, treatments, etc.
Name Date Treatment Better/Worse

Dr's Comments:_____