PATIENT NAME: _____ Case No. _____

DATE OF BIRTH: _____

FAIRVIEW PARK CHIROPRACTIC CENTER
TODD W. SMITH, D.C.
21881 LORAIN RD.
FAIRVIEW PARK, OH 44126
440-331-9033

DATE _____ INTERVIEWER _____

Do you have chest pain?	Yes ___	No ___
Do you have any change in bowel or bladder habits?	Yes ___	No ___
Do you have a sore that does not heal?	Yes ___	No ___
Do you have any unusual bleeding or discharge?	Yes ___	No ___
Do you have any thickening in your breasts or elsewhere?	Yes ___	No ___
Do you have indigestion or difficulty in swallowing?	Yes ___	No ___
Do you have a change in any wart or mole?	Yes ___	No ___
Do you have a nagging cough or hoarseness?	Yes ___	No ___
Do you have headaches for hours or days?	Yes ___	No ___
Do you have blurred vision?	Yes ___	No ___
Do you have night sweats?	Yes ___	No ___
Do you have pain in neck, jaw or face?	Yes ___	No ___
Do you have a drooping eyelid or any change in your pupils?	Yes ___	No ___
Do you have vertigo (dizziness)?	Yes ___	No ___
Do you have double vision?	Yes ___	No ___
Do you have any visual disturbances?	Yes ___	No ___
Do you have any nausea or vomiting?	Yes ___	No ___
Do you have any slurred speech?	Yes ___	No ___
Do you have any ringing in your ears?	Yes ___	No ___
Do you pass out easily (faint)?	Yes ___	No ___
Do you take birth control pills?	Yes ___	No ___
Do you have a history of stroke in your family?	Yes ___	No ___

What prescription medication are you taking if any?

[ ] High blood pressure medication
[ ] Blood thinners
[ ] Other_____
[ ] List allergies or adverse reactions to medications_____
_____

Have you ever had cancer? Yes ___ No ___

Does your pain ever wake you from a sound sleep? Yes ___ No ___

Are you losing weight now without trying? Yes ___ No ___

Are you coughing up blood or noticing it in your stools or urine? Yes ___ No ___

Have you had any loss of bladder or bowel control? Yes ___ No ___

Have you lost consciousness or had double vision recently? Yes ___ No ___

Are you seeing any other doctor now for any reason? Yes ___ No ___

Note: _____

Are you taking any medications or over-the-counter drugs? Yes ___ No ___

Please indicate type (aspirin, etc.) _____

What was the date of onset of your last menses? _____

SOCIAL HISTORY

SMOKER _____YES or _____NO, If Yes, How many packs_____
ALCOHOL _____YES or _____NO, If Yes, How much_____

FAMILY HISTORY

Did your mother or father have any of the following:
Put an **M** for mother, **F** for father, and **B** for both

( ) High Blood Pressure
( ) Heart Attack
( ) Emphysema
( ) Seizures-Convulsions
( ) HIV Positive
( ) Asthma
( ) Diabetes
( ) Kidney Disease
( ) Pacemaker
( ) Ulcer or Stomach Problems
( ) Stroke
( ) Arthritis-Rheumatism
( ) Mental Illness
( ) Thyroid Disease
( ) Circulation Problems
( ) Cancer
( ) Osteoporosis

Comments:_____

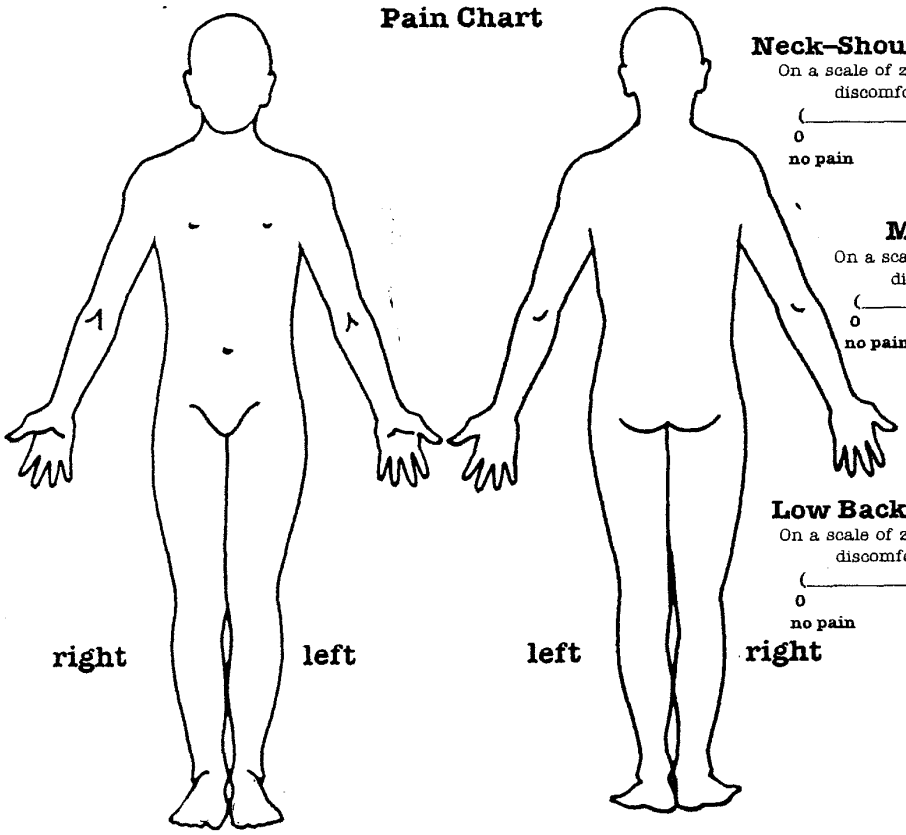
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

Pain Chart



Neck–Shoulder–Arm Pain
On a scale of zero to 10, I rate my discomfort as follows:
0 — 10
no pain — **severe pain**

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows:
0 — 10
no pain — **severe pain**

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:
0 — 10
no pain — **severe pain**

Date:_____

_____
Signature