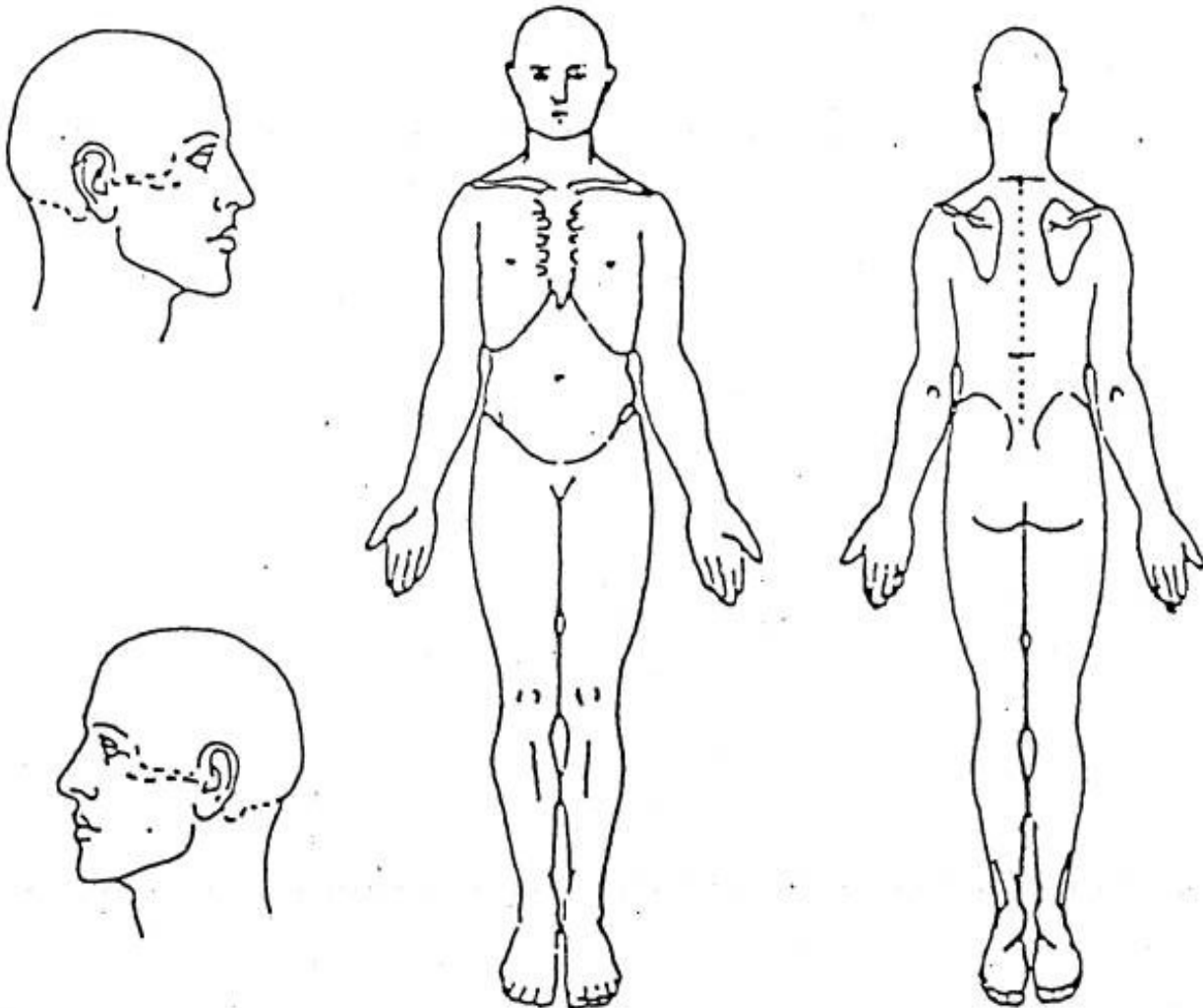


LOCATION OF SYMPTOMS: Please indicate any areas of discomfort or pain on the body chart below. Mark the areas where you feel the described sensations using the following symbols. Please include all affected areas and mark areas of radiation (traveling pain).

Pain = PPP
Numbness = NNN
Burning = BBB

Tingling = TTT
Cramping = CCC
Radiating Pain = RRR



PATIENT SIGNATURE _____

DATE _____

Mahler Family Chiropractic Center; 1144 Wyoming Ave. Forty Fort, PA. 18707; (570)283-1610

HIPPA Protected material confidential Page2

MEDICAL HISTORY

Please list all medications you're taking: _____

Please list all dietary supplements you're taking: _____

Please list all hospitalizations and surgeries (with dates): _____

Do you have any implants, surgical hardware, pacemakers or metallic sutures? Y N

Please list all traumas (sports injuries, automobile accidents, slips & falls): _____

Please list all known allergies: _____

[Females Only] Are you pregnant? Y N Date of the start of your last menstrual cycle: ___/___/___

Smoking (per/week)? _____ Caffeinated drinks per day (coffee, soda, tea, etc.)? _____

How many alcoholic drinks per week? _____ How many glasses of water per day? _____

How many times per week do you exercise? _____ How many hours of sleep per day? _____

How would you rate your diet? (circle one) Poor < 1 2 3 4 5 > Excellent

How would you rate your overall energy? (circle one) Poor < 1 2 3 4 5 > Excellent

How would you rate your stress levels? (circle one) Low < 1 2 3 4 5 > High

Describe your social activity. _____

On a scale of 1 through 10 (1 being the least, 10 being the most), how committed are you in wanting to get this problem handled once and for all? (circle)

1 2 3 4 5 6 7 8 9 10

PATIENT SIGNATURE _____ DATE _____

ROS/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back-pain (lower/mid)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone fracture
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concussion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/ Migraines
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual cramps (Abnormal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reproductive disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STD's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Travel abroad
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No health problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

List all siblings and their major health problems: No siblings No health issues

Other health information you feel is important: _____

PATIENT SIGNATURE _____

DATE _____