BUXBAUM FAMILY CHIROPRACTIC & MASSAGE

LAST NAME _____ FIRST NAME _____ MIDDLE _____

ADDRESS _____ BIRTHDATE _____ AGE _____

CITY _____ STATE _____ ZIP _____ HOW DID YOU HEAR ABOUT US? _____

OF CHILDREN _____ PRIMARY PHONE _____ EMAIL _____

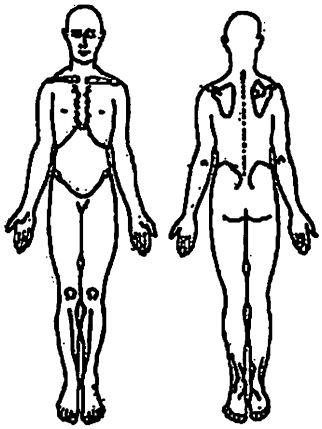
What is your major complaint? _____

_____

How long have you had this condition? _____ Have you had this or a similar condition in the past? _____

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and goes RE_EXAM: S - Same I – Improved G - Gone

Please mark the area(s) of pain



___ Heart Disease
___ Hospitalization
___ Hepatitis
___ Carpal Tunnel Syn.
___ Sciatica
___ Stroke
___ Varicose Veins
___ Herpes Simplex
___ Whiplash
___ Angina
___ Phlebitis/Thrombosis

___ Neck Problems
___ Shoulder Problems
___ Arm Problems
___ Numbness-Arms
___ Pain Between Shoulders
___ Low Back Problems
___ Leg Problems
___ Numbness-Legs
___ Loss of Feeling
___ Stiff Joints
___ Painful Joints

___ Sore Muscles
___ Walking Problems
___ Broken Bones
___ Muscle Cramps
___ Weak Muscles
___ Headaches
___ Dizziness
___ Fainting
___ Forgetfulness
___ Depression
___ Vision Problems

___ Allergies
___ Hay Fever
___ Asthma
___ Eczema
___ Shingles
___ Nausea
___ Poor Digestion
___ Ulcers
___ Diarrhea
___ Constipation
___ Kidney Infection

___ Restricts Daily Activities
___ Diabetes
___ Fibromyalgia
___ Contagious Diseases

___ Ear Pain/Noises
___ Tiredness/Fatigue
___ Disc Problems
___ Migraines

___ Menstrual Cramps
___ Hearing Loss
___ Insomnia
___ Repetitive Strain

___ Restricts Exercise
___ Pregnant
___ Blood Pressure High/Low

___ Ear Infections
___ Frequent Colds
___ Contagious Diseases

Specific Medical Conditions:

Arthritis: Yes ☐ No ☐ Bone Disease: Yes ☐ No ☐ Cancer: Yes ☐ No ☐ Diabetes: Yes ☐ No ☐

Epilepsy: Yes ☐ No ☐ Kidney Disease: Yes ☐ No ☐ Liver Disease: Yes ☐ No ☐ Lung Disease: Yes ☐ No ☐

Skin Conditions: Yes ☐ No ☐ Cardiovascular Disease: Yes ☐ No ☐

- This is a NEW / OLD illness. It WAS NOT / WAS treated before.

If treated before, what was done? _____

_____

- Name of Doctors: _____

- Have you ever had surgery or been hospitalized? Yes ☐ No ☐

List Surgeries: _____

_____

-Have you ever had Chiropractic care before? Yes ☐ No ☐

Name of Doctor _____ Date _____

-List time you had spinal X-rays or other X-rays: _____

From birth to present please list by date/describe

1.) Car Accidents _____

_____

_____

_____

2.) Falls/Injuries _____

_____

(Including Sports) _____

_____

-Medications you now take: _____