

Patient Information

Ira Chiro P.C.

Patient Condition

Reason for today's visit _____ When did symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Rate the severity of your pain on a scale from 1 (least) to 10 (severe) _____

Description of condition (circle all that apply): Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Other: _____

Is the pain:: Constant Frequent/Intermittent Occasional

Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that aggravate your condition: Sitting Standing Walking Bending
Lying Down Other: _____

Accident Information

Is your visit today due to an Auto, Workers Compensation or Personal Injury Accident? _____

If yes please inform front desk immediately.

Have you made a report of your accident? Yes No To whom? _____

Health History

What treatment have you already received for your condition? Medications Surgery
Physical Therapy Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for this condition: _____

Date of Last: Physical Exam _____ Spinal X-Ray _____
MRI, CT-Scan, Bone Scan _____

If you have had any of the following please place an "X" next to the condition:

| | | | |
|-------------------------|----------------------|---------------------------|------------------------|
| AIDS/HIV _____ | Emphysema _____ | Epilepsy _____ | Mononucleosis _____ |
| Stroke _____ | Osteoporosis _____ | | |
| Allergy Shots _____ | Fractures _____ | Multiple Sclerosis _____ | Suicide Attempt _____ |
| Anemia _____ | Glaucoma _____ | Mumps _____ | Thyroid issues _____ |
| Appendicitis _____ | Pacemaker _____ | Tuberculosis _____ | Venereal Disease _____ |
| Arthritis _____ | Parkinson's _____ | Tumors _____ | |
| Bleeding Disorder _____ | Hepatitis _____ | Pinched Nerve _____ | |
| Herniated Disk _____ | Herpes _____ | Prostate Problems _____ | |
| High Cholesterol _____ | Prosthesis _____ | High Blood Pressure _____ | |
| Cancer _____ | Kidney Disease _____ | Psychiatric Care _____ | Other _____ |
| Liver Disease _____ | Rheumatoid _____ | Rheumatic Fever _____ | _____ |
| Measles _____ | Arthritis _____ | | _____ |
| Diabetes _____ | Migraines _____ | Rheumatic Fever _____ | _____ |

Exercise: None Moderate Daily Heavy

Work Activity: Sitting Standing Light Labor Heavy Labor

Please list date and description of any Injuries/Surgeries you have had.

