Dreicer Chiropractic Center LLC
316 Broad St.
Red Bank, NJ 07701
732-758-9666

PERSONAL INFORMATION AND CONTACT

First name | Last name | Occupation

Address | City | State | Zip

Home phone | Work | Cell

Email | # of children

M☐ S☐ D☐ W☐
Marital status (check)

/ / – –
Date of birth | Social security number

M☐ F☐
Gender (check)

HAVE YOU EVER HAD CHIROPRACTIC CARE?

☐ Yes ☐ No

When? | Why? | Where?

Were x-rays taken?

☐ Yes ☐ No

When was your last adjustment?

CHECK OFF ANY ALLERGIES

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs ☐ Latex ☐ Molds ☐ Penicil-lin ☐ Ragweed/ Pollen

☐ Rubber ☐ Seasonal ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray ☐ Dye Other (list)

CHECK OFF ANY SURGERIES

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neuro-logical ☐ Shoulder ☐ Wrist

Other (list)

CHECK OFF ALL PAST MEDICAL HISTORY CONDITIONS

☐ Ankle pain ☐ Arm pain ☐ Arthritis ☐ Asthma ☐ Back pain ☐ Broken bones ☐ Cancer ☐ Chest pain ☐ Dep-ression ☐ Diabetes ☐ Dizziness

☐ Elbow pain ☐ Epilepsy ☐ Eye/vision problems ☐ Fainting ☐ Fatigue ☐ Foot pain ☐ Genetic Spinal Condition ☐ Hand Pain ☐ Head aches ☐ Hearing Problems ☐ Hepatitis

☐ High blood pressure ☐ Hip pain ☐ HIV ☐ Jaw pain ☐ Joint stiffness ☐ Knee pain ☐ Leg pain ☐ Menstrual problems ☐ Mid-back pain ☐ Minor heart problem ☐ Multiple sclerosis

☐ Neck pain ☐ Neuro-logical prob-lems ☐ Pace-maker ☐ Parkin-son's ☐ Polio ☐ Prostate problems ☐ Shoulder pain ☐ Signifi-weight change ☐ Spinal cord injury ☐ Sprain/ strain ☐ Stroke/ heart attack

Other (list)

CHECK OFF TYPES OF MEDICATION YOU ARE TAKING

☐ Anxiety ☐ Muscle relaxers ☐ Pain killers ☐ Insulin ☐ Birth control ☐ Cardio-vascular ☐ Allergy ☐ Seizure

Other (list)

CHECK OFF YOUR FAMILY HISTORY

☐ Arthritis ☐ Anxiety ☐ Asthma ☐ Back pain ☐ Cancer ☐ Dep-ression ☐ Diabetes ☐ Epilepsy ☐ Genetic spinal condition

☐ High blood pressure ☐ Heart problems ☐ Multiple sclerosis ☐ Parkin-son's ☐ Polio ☐ Prostate problems ☐ Stroke/ heart attack

Other (list)

HAVE YOU HAD ANY AUTO OR OTHER ACCIDENTS?

☐ Yes ☐ No Describe

LIFESTYLE

Do you smoke? ☐ Yes ☐ No How many per day

Do you drink alcohol? ☐ Yes ☐ No How many per day

Do you drink caffeine? ☐ Yes ☐ No

Date of last physical examination

Do you exercise?

☐ Yes ☐ No What forms and how often

REASON FOR VISIT

What is your ***major*** complaint? Date problem began

MAIN REASON FOR CONSULTING OFFICE

☐ Become pain free ☐ Explanation of my condition ☐ Learn how to care for condition ☐ Reduce symptoms ☐ Resume normal activity level

How did this problem begin? (Falling, lifting, etc.)

How is your condition changing?

☐ Getting better ☐ Getting worse ☐ Not changing

How often do you experience your symptoms?

☐ Constantly *76-100% of day* ☐ Frequently *51-75% of day* ☐ Ocassionaly *26-50% of day* ☐ Intermittently *0-25% of day*

Have you had condition in the past?

☐ Yes ☐ No

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Rate pain from 1–10 (check) *0=no pain and 10=excruciating pain*

Describe the nature of your symptoms (check all that apply).

☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating pain ☐ Tight-ness ☐ Stabbing ☐ Throbbing

Other (list)

How do your symptoms affect your ability to perform daily activities such as working or driving?

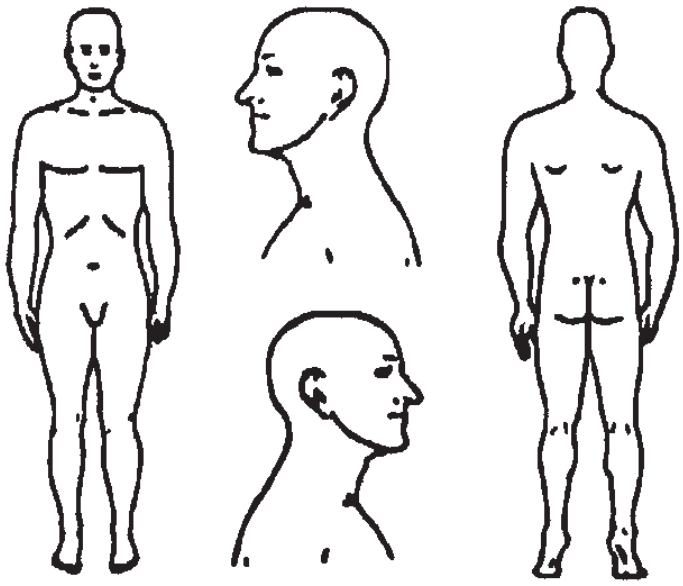
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

0=no effect and 10=no possible activities (check)

What activities aggravate your condition? (work, exercise, etc.)

What makes your pain better? (ice, heat, massage, etc.)

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM TO THE RIGHT



SECOND REASON FOR VISIT

What is your ***second*** complaint? Date problem began

MAIN REASON FOR CONSULTING OFFICE

☐ Become pain free ☐ Explanation of my condition ☐ Learn how to care for condition ☐ Reduce symptoms ☐ Resume normal activity level

How did this problem begin? (Falling, lifting, etc.)

How is your condition changing?

☐ Getting better ☐ Getting worse ☐ Not changing

How often do you experience your symptoms?

☐ Constantly *76-100% of day* ☐ Frequently *51-75% of day* ☐ Ocassionaly *26-50% of day* ☐ Intermittently *0-25% of day*

Have you had condition in the past?

☐ Yes ☐ No

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Rate pain from 1–10 (check) *0=no pain and 10=excruciating pain*

Describe the nature of your symptoms (check all that apply).

☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating pain ☐ Tight-ness ☐ Stabbing ☐ Throbbing

Other (list)

How do your symptoms affect your ability to perform daily activities such as working or driving?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

0=no effect and 10=no possible activities (check)

What activities aggravate your condition? (work, exercise, etc.)

What makes your pain better? (ice, heat, massage, etc.)