STEPHEN F. OSWALD AND ASSOCIATES

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Name:_____Age:_____Date_____
Address:_____City:_____State: _____Zip:_____
Phone (H)_____(C) _____(Work):_____
Date of Birth: _____Sex:☐M ☐F Email: _____
Past Chiropractic Care: ☐Yes ☐No When?:_____ Doctor's Name:_____
Results:_____ Referred by:_____

Pain Symptoms (In order of severity)

1._____Began (Mo/Yr)_____Previous Episodes: _____
2._____Began (Mo/Yr)_____Previous Episodes: _____
3._____Began (Mo/Yr)_____Previous Episodes: _____

Please mark the intensity of your pain today.
0 – NO PAIN 10 – INTENSE PAIN
Example: _____Neck_____
○0 ○1 ○2 ○3 ◉4 ○5 ○6 ○7 ○8 ○9 ○10
1._____
○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
2._____
○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
3._____
○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

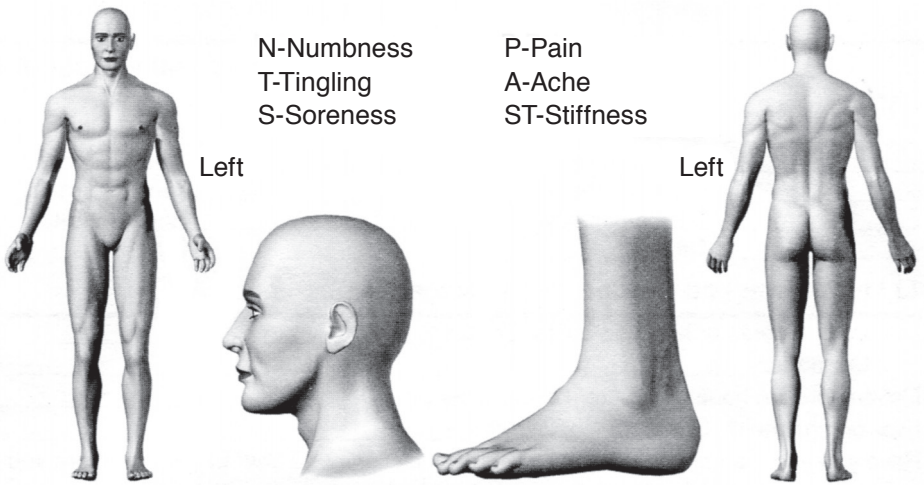
DOCTORS USE ONLY

_____
_____
_____

Please mark area & type of pain on the drawings using the codes listed below

N-Numbness
T-Tingling
S-Soreness

P-Pain
A-Ache
ST-Stiffness



HABITS

☐Smoking ☐Packs/Day
☐Alcohol ☐Daily ☐Y☐N
☐Caffeine ☐Cups/Day

EXERCISE

☐None
☐Light Activity
☐Moderate Activity
☐Active
☐Very Active

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Other
Mother	☐	☐	☐	☐	☐ ____
Father	☐	☐	☐	☐	☐ ____
Brother, # of___	☐	☐	☐	☐	☐ ____
Sister, # of___	☐	☐	☐	☐	☐ ____

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS

☐Appendicitis
☐Pneumonia
☐Polio
☐Tuberculosis
☐Whooping Cough
☐Asthma
☐Anemia
☐Measles
☐Mumps
☐Chicken Pox
☐Diabetes
☐Cancer
☐Migraine Headaches
☐Heart Disease
☐Flu
☐Pleurisy
☐Alcoholism
☐STDs
☐Herpes
☐Arthritis
☐Epilepsy
☐HIV Positive

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ☐ Never ☐ Past ☐ Now

Never	Past	Now	GENERAL SYMPTOMS
☐	☐	☐	Allergy (What?) _____
			_____
☐	☐	☐	Bronchitis
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Depression
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of Sleep
☐	☐	☐	Loss of Weight
☐	☐	☐	Nervousness
☐	☐	☐	Neuralgia
☐	☐	☐	Sweats
☐	☐	☐	Wheezing

MUSCLES/JOINT/BONES

☐	☐	☐	Arm/Shoulder Symptoms
☐	☐	☐	Backache
☐	☐	☐	Foot Symptoms
☐	☐	☐	Hernia
☐	☐	☐	Hip Symptoms
☐	☐	☐	Pain Between Shoulders
☐	☐	☐	Painful Tail Bone
☐	☐	☐	Scoliosis
☐	☐	☐	Stiff Neck
☐	☐	☐	Swollen Joints
☐	☐	☐	Tremors/Twitching

Never	Past	Now	GASTRO-INTESTINAL
☐	☐	☐	Abdominal Pain
☐	☐	☐	Belching/Gas/Bloating)
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Excessive Eating
☐	☐	☐	Excessive Thirst
☐	☐	☐	Gall Bladder Trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Indigestion
☐	☐	☐	Jaundice
☐	☐	☐	Liver Trouble
☐	☐	☐	Nausea
☐	☐	☐	Poor Appetite
☐	☐	☐	Poor Digestion
☐	☐	☐	Rectal Bleeding
☐	☐	☐	Stomach Pain
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting Blood

CARDIO-VASCULAR

☐	☐	☐	Heart Symptoms
☐	☐	☐	High Blood Pressure
☐	☐	☐	Low Blood Pressure
☐	☐	☐	Pain Over Heart
☐	☐	☐	Poor Circulation
☐	☐	☐	Rapid Heart
☐	☐	☐	Slow Heart
☐	☐	☐	Stroke
☐	☐	☐	Swelling Ankles
☐	☐	☐	Varicose Veins

Never	Past	Now	EYE/EAR/ NOSE/THROAT
☐	☐	☐	Asthma
☐	☐	☐	Bleeding Gums
☐	☐	☐	Deafness
☐	☐	☐	Difficulty Swallowing
☐	☐	☐	Diplopia
☐	☐	☐	Earache
☐	☐	☐	Ear Discharge
☐	☐	☐	Enlarged Thyroid
☐	☐	☐	Frequent Colds
☐	☐	☐	Hay Fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nosebleeds
☐	☐	☐	Pain in Eyes
☐	☐	☐	Poor Vision
☐	☐	☐	Persistent Cough
☐	☐	☐	Sinusitis
☐	☐	☐	Tinnitus
☐	☐	☐	Tonsillitis

SKIN OR ALLERGIES

☐	☐	☐	Boils
☐	☐	☐	Bruising Easily
☐	☐	☐	Dryness
☐	☐	☐	Eczema
☐	☐	☐	Hives or Allergy
☐	☐	☐	Itching
☐	☐	☐	Psoriasis
☐	☐	☐	Sensitive Skin
☐	☐	☐	Skin Eruptions

Never	Past	Now	RESPIRATORY
☐	☐	☐	Chest Pain
☐	☐	☐	Chronic Cough
☐	☐	☐	Difficulty Breathing
☐	☐	☐	Spitting Blood
☐	☐	☐	Spitting Phlegm

GENITO-URINARY

☐	☐	☐	Bed Wetting
☐	☐	☐	Blood in Urine
☐	☐	☐	Frequent Urination
☐	☐	☐	Lack of Bladder Control
☐	☐	☐	Kidney Infection
☐	☐	☐	Painful Urination

FOR WOMEN ONLY

☐	☐	☐	Cramps or Backaches
☐	☐	☐	Cysts
☐	☐	☐	Excessive Flow
☐	☐	☐	Hot Flashes
☐	☐	☐	Irregular Cycle
☐	☐	☐	Miscarriage
☐	☐	☐	Painful Periods
☐	☐	☐	Vaginal Discharge

☐Y ☐N Pregnant at this time?

☐Y ☐N Have you had a mammogram?

SURGERIES OR PROCEDURES ☐ I have never had any surgeries

DATE		DATE		DATE	
_____	Tonsillectomy	_____	Tubes in Ears	_____	Sinus
_____	Gall Bladder	_____	Appendectomy	_____	Hernia
_____	Back Surgery	_____	Female Organs	_____	Thyroid
_____	Knee Surgery	_____	Rectal Surgery	_____	Stomach
_____	Other_____	_____	Other_____	_____	Other_____

List any accidents or falls and dates: ☐ Car: _____ ☐ Recreation_____ ☐ Sports: _____

☐ School _____ ☐ Other:_____

List any broken bones or dislocations: _____

Ever on crutches ☐ Yes ☐ No Why? _____

Have you ever had any spinal taps or spinal injections? ☐Yes ☐No Were you ever knocked unconscious? ☐ Yes ☐ No

Have you ever had a lapse of memory? ☐ Yes ☐ No

Have you ever had X-rays taken? ☐ Yes ☐ No

Do you suffer from any condition other than that for which you are now consulting us?_____

Are you presently taking any medication – prescription or over-the-counter? ☐ Yes ☐ No What drugs?_____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The doctor's office will prepare forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the doctor's office will be credited to my account upon receipt. All services rendered to me are my personal responsibility and I agree to pay at the time of service.

I authorize the doctor to examine and treat my condition as deemed appropriate through the use of chiropractic health care and I give authority for these procedures to be performed. I am the responsible party for payment of any treatment received or incurred on this account.

Patient's/Guardian's Signature:_____ Date:_____