HANSON CHIROPRACTIC CLINIC, 306 N MILL ST, FERTILE, MN 56540 218-945-3220

Name_____ Date_____

1. Describe your symptoms:_____
   a. When did your symptoms start? _____
   b. What caused your symptoms to begin? _____
2. How often do you experience your symptoms? _____
   _____Constantly (76 – 100% of the day)
   _____Frequently (51-75% of the day)
   _____Occasionally (26 – 50% of the day)
   _____Intermittently (0 – 25% of the day)
3. What describes the nature of your symptoms?
   _____sharp _____shooting _____stiff/sore
   _____dull ache _____burning _____tense/tight
4. How are your symptoms changing?
   _____getting better _____not changing _____getting worse
   What makes your symptoms worse? _____
   What makes your symptoms better? _____
5. Circle the lowest AND highest levels of your symptoms: (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst)
   a. Are you pregnant? Yes No Not sure
   b. Are you currently on any medications or supplements? List them please.

      _____ _____ _____
      _____ _____ _____
      _____ _____ _____
      _____ _____ _____
   c. Do you smoke? Yes No Previously
   d. Allergies: Environmental? _____
      Medications? _____
      Food? _____
   e. Do you drink alcohol, coffee, or pop? If so, how many per day? _____
6. Who have you seen for your symptoms?
   ____No one ____chiropractor ____medical doctor ____physical therapist _____other
7. Have you had similar symptoms in the past? Yes No
   If you received treatment in the past for similar symptoms, who did you see?
   ____this office _____other chiropractor ____medical doctor ____P. T. ____other
8. Do you have any other health problems such as……
   ___Heart or blood pressure problems ____gastrointestinal problems _____organ (liver, kidney, etc.) problems
   ____urinary ____musculoskeletal _____arthritis
   ____eye, ear, nose, throat ____respiratory/lungs _____other health concerns/problems
   ____Unusual bleeding ____Unexplained Weight Loss or Gain ____Extreme Fatigue
   If you checked any of these, please explain: _____
   _____
9. Do you have family members that have any of the following health concerns? M= Mother, F= Father, S= Sibling.
   1.Arthritis_____ 2. Osteoporosis_____
   3. High blood pressure_____ 4.Stroke_____
   5. Heart Attack_____ 6.Diabetes_____
   7.Cancer_____What kind?_____
   8.Back Problems_____ What kind of problem?_____

10. Type of care desired: _____Corrective _____Symptom Relief

Signature_____Date_____