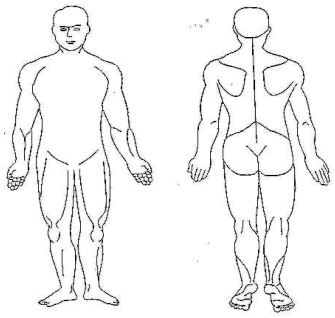
HANSON CHIROPRACTIC CLINIC, 306 N MILL ST, FERTILE, MN 56540 218-945-3220

Name_____Birthdate_____Date_____

1. Describe your symptoms:_____
   a. When did your symptoms start?_____
   b. What caused your symptoms to begin?_____

(Mark areas involved)



2.How often do you experience your symtoms?

_____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 symptoms:(None) 0 1 2 3 4 5 6 7 8 9 10 (Worst)
6. a. Are you pregnant? _____Yes _____No _____Not sure
   b. Please list the medications or supplements you are currently taking.

   _____ _____ _____
   _____ _____ _____
   _____ _____ _____

   c. Do you smoke? _____Yes _____No _____Previously
   d. Allergies: Environmental_____
      Medication_____
      Food_____
   e. Do you drink alcohol, coffee, pop? If so, how many per day?_____
7. Who have you seen for your symptoms?
   ____No one ____chiropractor ____medical doctor ____physical therapist ____other
8. Do you have any other health problems such as ……..
   ____heart or blood pressure ____gastrointestinal ____organ (liver,kidney,etc.)
   ____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
   Arthritis_____ Osteoporosis_____
   High Blood Pressure_____ Stroke_____
   Heart Attack_____ Diabetes_____
   Cancer_____What type?_____
   Back problems_____What kind of problem?_____
10. Type of care desired: _____Corrective _____Symptom Relief

, Signature_____Date_____