PARK EAST CHIROPRACTIC

Dr. Troy Friesen: Chiropractor, Wellness Advisor

One body...live well

Welcome! Please complete the following information so we can properly serve you.
All information provided is kept confidential. Please ask if you need assistance.

Date _____

Name_____ I like to be called _____
(First) (Middle) (Last)

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone _____ Cell _____

Do you prefer to receive calls at: ☐ Home ☐ Cell ☐ Work ☐ No Preference

Social Security #_____Birth Date _____Male____ Female ___

Employer_____

Email _____
(This would be used only to send clinic information and news on an occasional basis)

Primary Physician_____ Clinic _____
☐ Please check if you do not want us to contact

PLEASE COMPLETE THE SECTION BELOW ONLY IF RESPONSIBLE PARTY IS SOMEONE BESIDES THE PERSON NAMED ABOVE.

Name_____ Birth Date _____
(First) (Middle) (Last)

Address_____City_____ State_____Zip_____

Home Phone_____ Work Phone _____ Cell _____

Social Security #_____ Employer_____

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PARK EAST CHIROPRACTIC

HEALTH QUESTIONS

Name _____ Date _____

Current symptoms / reason for visit _____
_____
_____
_____

When did you first notice the symptoms? _____

Have you had similar symptoms in the past? ☐ Yes ☐ No

Are your symptoms ☐ Getting worse ☐ Not changing ☐ Getting better

How would you describe your symptoms ☐ Sharp ☐ Dull ☐ Numb ☐ Tingling ☐ Burning ☐ Shooting ☐ Achey ☐ Stiff ☐ Swelling ☐ Cramping

Have you seen other doctors / therapists for this condition? ☐ Yes ☐ No
If you indicated yes, did you see ☐ MD ☐ PT ☐ DC ☐ Massge Therapist ☐ Other

What tests have you had for your symptoms? ☐ X-ray ☐ MRI ☐ CT ☐ EMG ☐ Other

Circle your pain rating on a scale of 0-10: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Please check all that apply. My condition limits my ability to:

☐ lift ☐ walk ☐ sit ☐ stand ☐ sleep ☐ drive ☐ work
☐ exercise ☐ recreate ☐ socialize

Please check all that apply. My day normally includes:

☐ Sitting more than 6 hrs ☐ Standing more than 6 hrs
☐ computer work more than 6 hours ☐ heavy lifting
☐ Driving more than 6 hours

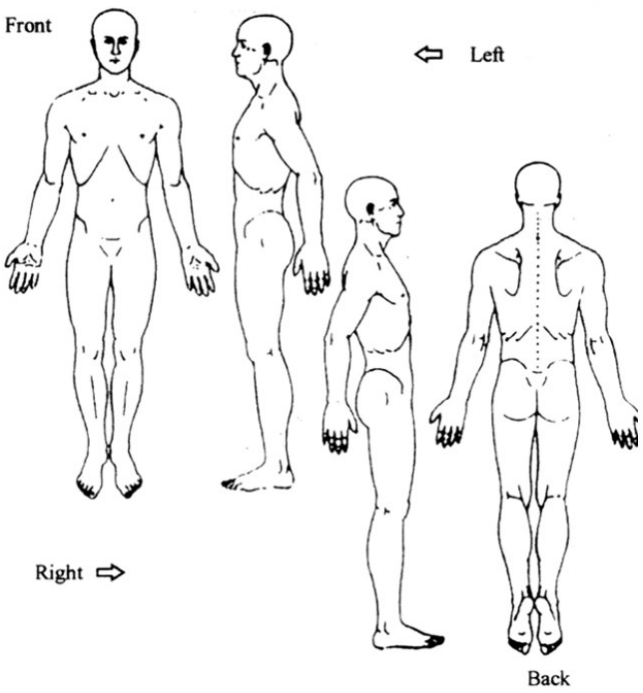
Circle how many times per week on average you exercise 0 1 2 3 4 5 6 7

What type of exercise do you do?

_____

Have you been to a chiropractor before? ☐ Yes ☐ No

Please indicate on the body below where your symptoms are located.



PARK EAST CHIROPRACTIC HEALTH QUESTIONNAIRE

Name _____ Date _____

What is your Height? _____ Weight_____

Place a check in the box if you have EVER had this condition.

- ☐ Migraine headache
- ☐ Fracture
- ☐ Arthritis
- ☐ Cauda Equina Syndrome
- ☐ Epilepsy
- ☐ Kidney problem
- ☐ Asthma
- ☐ Chronic Sinusitis
- ☐ Depression
- ☐ Myositis ossificans
- ☐ Pain longer than 6 weeks
- ☐ Infection of bone
- ☐ Leg Calve Perthes
- ☐ Scoliosis
- ☐ Stroke or Heart problem
- ☐ Prostate problem
- ☐ Thyroid disorder
- ☐ Lymes disease
- ☐ Disc problem
- ☐ Nervous system disorder
- ☐ Connective tissue disorder
- ☐ Cancer
- ☐ Myelopathy
- ☐ Transient Ischemic Attack
- ☐ Hemophelia
- ☐ HIV or AIDS
- ☐ Pregnancy
- ☐ High Cholesterol
- ☐ Gout
- ☐ Thrombosis / embolism / phlebitis

Place a check in the box if you CURRENTLY HAVE this condition.

- ☐ Headaches
- ☐ Rheumatoid Arthritis
- ☐ Bleeding disorder
- ☐ Diabetes
- ☐ Pregnant
- ☐ Blood Clots
- ☐ Pain longer than 6 weeks
- ☐ Metal implant
- ☐ High blood pressure
- ☐ Smoking / tobacco use
- ☐ Osteoporosis
- ☐ Easy bruising
- ☐ Recent surgery
- ☐ Blood thinning medication
- ☐ Abnormal weight gain / loss
- ☐ Allergies
- ☐ Fibromyalgia

Place a check in the box if you have a FAMILY HISTORY of this condition (mother, father, sibling, child).

- ☐ Migraine headaches
- ☐ Connective tissue disorder
- ☐ Arthritis
- ☐ Disc problem
- ☐ Osteoporosis
- ☐ Back or Neck problem
- ☐ Cancer
- ☐ Stroke
- ☐ Neurological condition
- ☐ Diabetes
- ☐ Scoliosis
- ☐ Aneurysm
- ☐ Prostate problem
- ☐ Multiple Sclerosis

Other than indicated above, are you currently treating for or have been diagnosed with any other condition?

_____

List all prescription medication, over the counter medication, herbal supplements and vitamins you are taking:

_____

List all surgical procedures you have had:

_____