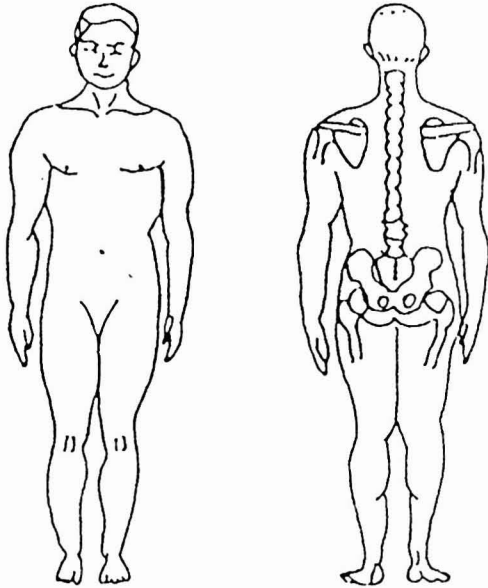


# MEDICAL INFORMATION

Please print your full name: \_\_\_\_\_

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off and on. When standing or sitting.

## Complete these Diagrams



## Major Complaints

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How did this condition develop? What caused it? How did it start?

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When was the very first time you were aware of this problem?

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Have you ever had this problem or similar problem before? If yes, please explain.

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Have you ever received any treatment for this condition? If yes, where and when, and what were your results?

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**HELPING HANDS  
CHIROPRACTIC CENTER**

4400 NW 23rd Avenue  
Gainesville, Florida 32606

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Has this problem been getting better, worse, or staying the same?

\_\_\_\_\_

Is there anything you do that makes your condition worse/better?

\_\_\_\_\_

How has this condition affected your life?

1. Home Life: \_\_\_\_\_

2. Occupational Life: \_\_\_\_\_

3. Recreational Life: \_\_\_\_\_

4. Rest and Sleep: \_\_\_\_\_

Have you ever been in an automobile accident?

\_\_\_\_\_ Past year \_\_\_\_\_ Past 5 years \_\_\_\_\_ Over 5 years \_\_\_\_\_ Never

Any accidents, falls, that might have caused your problem?

\_\_\_\_\_

Is there any medical diagnosis for your present complaint?

\_\_\_\_\_

Please list any surgeries you have had.

\_\_\_\_\_

Please list any medications you are currently taking and for how long.

\_\_\_\_\_

Have you consulted a chiropractor in the past? If yes, please give name, dates and problem at the time.

\_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_