205 S. Salina Street, Syracuse
Inside Metro Fitness
DrEric@CuseChiro.com
315-217-1772

Your Information

Title: ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr. Sex: ◯ Male ◯ Female Birthdate: _____/_____/_____

First Name: _____ Middle Initial: _____Last Name: _____

Address:_____

City: _____ State: _____Zip Code _____

Cell: _____ Email: _____

Who do we have to thank for your visit? ◯ Staff Member/Dr. Eric

◯ Existing Patient _____ ◯ Primary Care/Specialist _____

◯ Google ◯ Yelp ◯ Social Media _____ ◯ Other_____

History of Present Illness

Reason for today's visit? _____

How did your symptoms start? _____ When?____/____/_____

Have you had this pain before? ◯ No ◯ Yes Have you been treated for this condition? ◯ No ◯ Yes

If Yes, by whom? _____

And what type of treatment did you receive? ◯ Chiropractic ◯ PT ◯ Other _____

Describe your complaint? ◯ Dull ◯ Aching ◯ Sharp or Stabbing ◯Throbbing ◯ Pins & Needles ◯ Burning

It is: ◯ Getting Worse ◯ Getting Better ◯ Stays the same

What makes your symptoms **WORSE**? _____

What makes your symptoms **BETTER**? _____

Average Pain Intensity: **no pain** **worst pain**

Last 24 hours: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Past week: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

How often do you experience symptoms:

◯ Constantly (76-100% of the time) ◯ Occasionally (26-50% of the time)

◯Frequently (51-75% of the time) ◯ Intermittently (1-25% of the time)

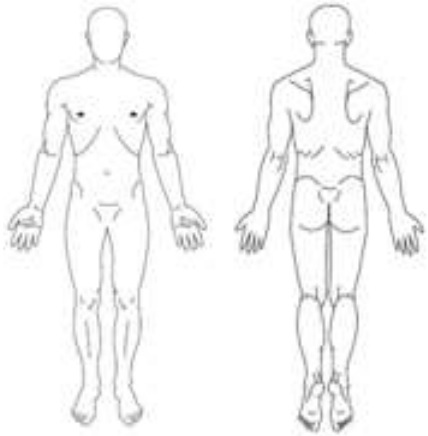
How much have your symptoms interfered with your daily activities?

◯ Not at all ◯ A little bit ◯ Moderately ◯Quite a bit ◯Extremely

In General, would you say your overall health right now is?

◯ Excellent ◯ Very good ◯ Good ◯ Fair ◯ Poor

Please illustrate your symptoms.



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Medical History

Please list any major surgeries:_____

Please list any *other* hospitalizations: _____

Are you taking any prescription medications? ◯ No ◯ Yes _____

Are you taking any OTC medications? ◯ No ◯ Yes _____

Have you had any significant past trauma? ◯ No ◯ Yes _____

Describe your level of exercise? ◯ Heavy ◯ Daily ◯ Moderate ◯ Light ◯ None

Have you ever smoked? ◯ Never Smoker ◯ Former Smoker ◯ Current Smoker (_____packs/day ____years)

How many caffeinated drinks, on average, do you consume in a day?_____

How many alcoholic drinks, on average, do you consume in a week?_____

How would you describe your level of stress? ◯ Heavy ◯ Moderate ◯ Light

Health and Family History

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Drug/Alcohol Dependence
□	□	Low Back Pain	□	□	Angina	□	□	Allergies
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Asthma
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Chronic Sinusitis
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Depression
□	□	Hand Pain	□	□	Painful Urination	□	□	Systemic Lupus
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Epilepsy
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	Dermatitis/Eczema/Rash
□	□	Knee Pain	□	□	Dizziness	□	□	HIV/AIDS
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	□	□	Abnormal Weight Loss
□	□	Jaw Pain	□	□	Abdominal Pain	□	Other:_____	
□	□	Joint Pain/Stiffness	□	□	Ulcer			
□	□	Arthritis	□	□	Hepatitis	**For Females Only**		
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder	□	□	Birth Control Pills
□	□	Cancer	□	□	General Fatigue	□	□	Hormonal Replacement
□	□	Tumor	□	□	Visual Disturbances	□	□	**Pregnancy**

Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ ALS □ Lupus □ Lyme
□ Heart Problems □ Cancer Diabetes □ Connective Tissue Disorders

How committed are you to your health? ◯ Very Committed ◯ Somewhat Committed ◯ Not Committed