ChiroRehab OF TEXAS
PAIN PERFORMANCE WELLNESS

Patient Name:_____ **Date:**_____

Name_____ **Date** _____

Address _____**City/State/Zip:**_____

Date of Birth _____ **Primary Phone:**_____

Sex: M F **Marital Status: Single, Married, Divorced, Widowed**

Email:_____

Social Security # _____ **Driver's License#**_____

Emergency Contact:_____ **Phone:**_____

Relationship:_____

Who may we thank for referring you? _____

Reason for seeking care:_____

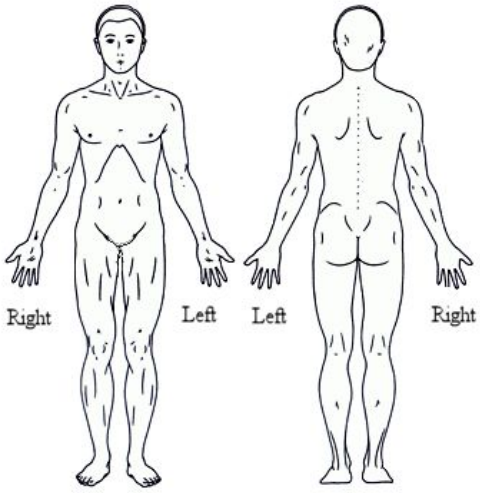
Have you seen other health care providers for this:_____

Is this related to an injury? __yes __no __On the job __Auto ___Other

Have you received chiropractic care previously? __yes ___no

Using the symbols below, mark on the pictures where you feel:

- **Numbness = = =**
- **Dull Ache 000**
- **Burning XXX**
- **Sharp/Stabbing ///**
- **Pins, Needles, Tingling +++**
- **Tightness/Tension ^^^**



Please circle the degree of discomfort: 0, none, 10 worst

0 1 2 3 4 5 6 7 8 9 10

Is there a certain time of day your symptom/s is/are Worse:_____

What activities aggravate your condition/pain?_____

What activities lessen your condition/pain?_____

Is this condition progressively getting worse?_____

Patient Signature/Date:_____

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Do you or any family members have any of the following?

F-for family C- you currently P- You in the past

__Depression	__Brain Fog	__Headache/Migraine
__Heart Attack	__Hypoglycemia	__Neuropathy/Nerve issues
__Diabetes	__Anemia	__Poor Sleep
__Thyroid Disease	__Cancer	__Dizziness
__Gallbladder Disease	__High Blood Pressure	__Arthritis
__Kidney Disease	__Intestine Problems	__Weight Gain
__Stroke	__Shortness of Breath	__Back Pain
__Fatigue	__High Cholesterol	__Carpal Tunnel
__Eczema	__PMS	__Emotional Imbalance
__Autoimmune Disease	__Digestive Issues	__Bowel Issues
__Asthma	__Allergies	__Chronic Sinusitis
__Acne	__Psoriasis	__Hives/Skin Rashes

1. **How have you taken care of your health in the past?**
    a. **Medications**
    b. **Emergency Room/Urgent Care**
    c. **Routine Medical**
    d. **Exercise**
    e. **Nutrition/Diet**
    f. **Holistic Care**
    g. **Vitamins**
    h. **Chiropractic**
    i. **Other:**_____

2. **Are there health conditions you are afraid this might turn into?**
    a. **Family health problems**
    b. **Heart disease**
    c. **Cancer**
    d. **Arthritis**
    e. **Fibromyalgia**
    f. **Depression**
    g. **Chronic Fatigue**
    h. **Surgery**
    i. **Dependent on medication**

3. **What do you hope to achieve from working with us?**

_____

_____

_____

Patient Signature/Date:_____