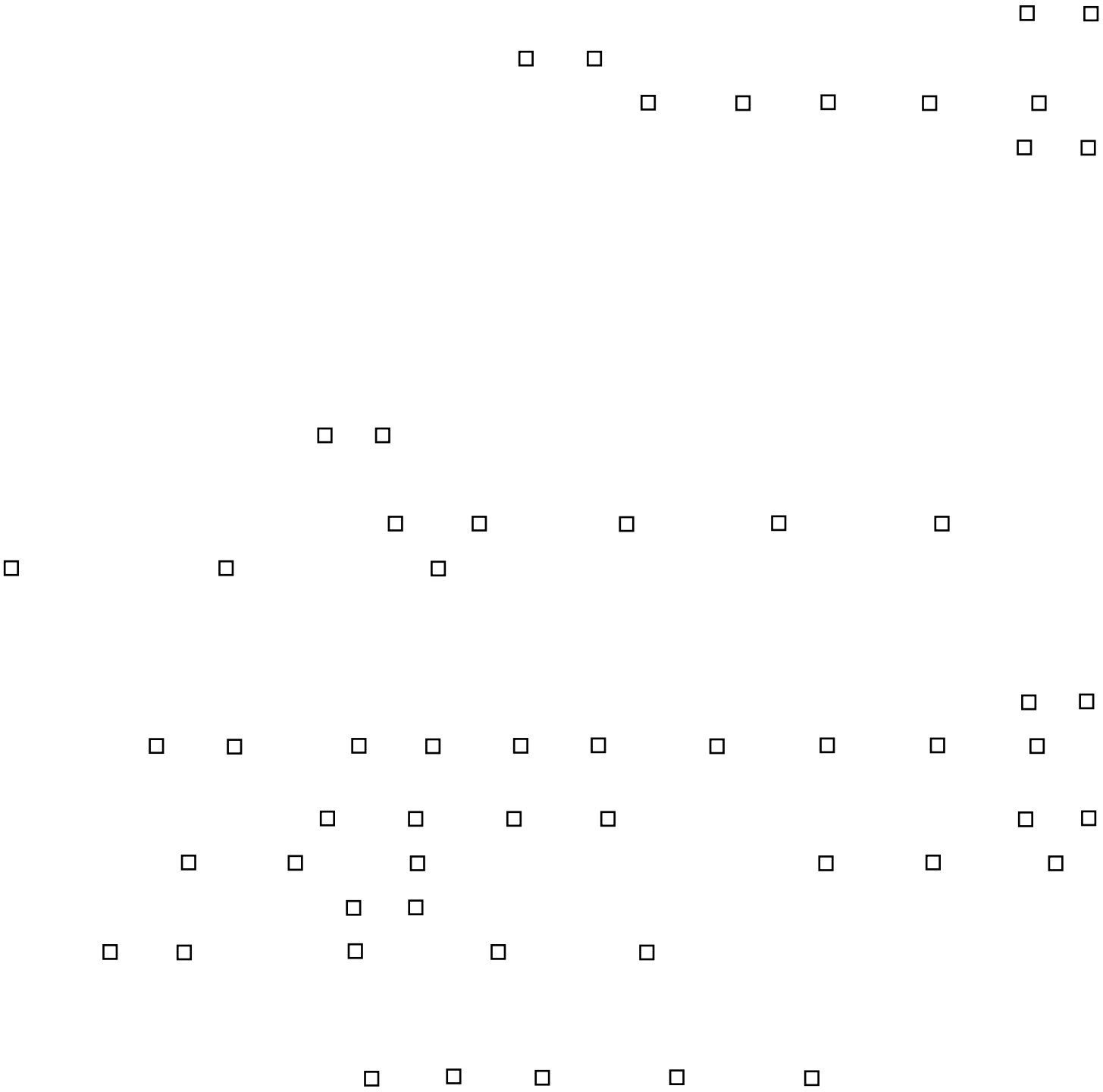


Please select

PATIENT INFORMATION CONTINUED

Have you had injuries in the past? Please include all auto accidents, falls, sports trauma, etc and dates: _____

_____

_____

Have you had any surgeries or hospitalizations? Please list dates as well:_____

_____

Please list any diseases and dates: _____

_____

Are you taking any medications? List dosage and reason for taking: _____

_____

Are you taking any supplements? List dosage and reason for taking: _____

_____

Do you drink/eat dairy? ❑ Yes ❑ No Servings/week _____ Do you eat fast food? ❑ Yes ❑ No Times/week _____

How often do you drink alcohol? ❑ Never ❑ Rarely (1x/mon) ❑ Occasionally (1x/wk) ❑ Moderately (2-3x/wk)
❑ Frequently (4-5x/wk) ❑ Excessive (6-7x/wk)

How often do you exercise? ❑ Daily (6-7x/wk) ❑ Frequently (4-5x/wk) ❑ Intermittently (2-3x/wk) ❑ Occasionally (1-2x/wk) ❑ Never

How much do you smoke? ❑ Never ❑ 1/2 pack/day or less ❑ 1 pack/day ❑ 1-2 packs/day ❑ More than 2 packs/day

How old is you mattress? _____ years

What position do you sleep in? ❑ Back ❑ Stomach ❑ Side with legs together ❑ Side with top leg higher

What is your stress level, on a scale of 0-10? Please select

Describe your job duties: _____

_____

How many hours do you sit in a chair per day?_____ How many hours per week do you work? _____

I have read and reviewed the information contained herein and represent that it is true, correct, and complete. I understand that the doctor is relying upon the information in rendering treatment.

_____ _____

Patient Signature (Parent or Guardian if necessary) Date

OFFICE USE ONLY

Dominate Hand: ❑ R ❑ L Height: _____ Weight: _____ BP: _____/_____

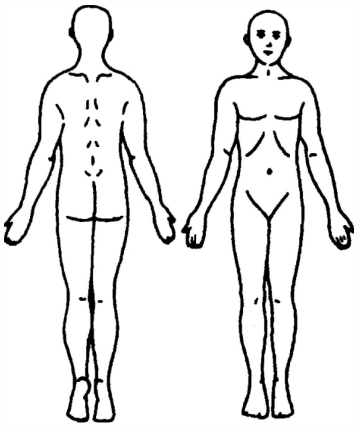
Respirations: _____ Pulse: _____ Self Manipulate? ❑ Y ❑ N C / T / L How often _____

Radiation to extremities: ❑ Y ❑ N Other systems involved? ❑ Y ❑ N _____

↑ pain: Flex / Ext / RRot / LRot / LLF / RLF C / T / L / UE / LE R/L

↓ pain: _____

↓ ROM: Flex / Ext / RRot / LRot / LLF / RLF C / T / L _____



LEAKE
CHIROPRACTIC

104 Sycamore Estates Drive
Aurora, IN 47001
(812) 539-CARE (2273)
leakefrontdesk@yahoo.com
LeakeChropractic.com

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ❑ Pneumonia
- ❑ Pleurisy
- ❑ Diabetes
- ❑ Anemia
- ❑ Eczema
- ❑ Mumps
- ❑ Polio
- ❑ Epilepsy
- ❑ Heart Disease
- ❑ Influenza
- ❑ Chicken Pox
- ❑ Whooping Cough
- ❑ Lumbago
- ❑ Rheumatic Fever
- ❑ Arthritis
- ❑ Cancer
- ❑ Measles
- ❑ Small Pox
- ❑ Tuberculosis
- ❑ Mental Disorders
- ❑ Thyroid

INTAKE:

Coffee _____ oz/day
Tea _____ oz/day
White Sugar _____ oz/day

Genito-Urinary
- ❑ Bladder Trouble
- ❑ Painful/Excessive Urination
- ❑ Discolored Urine

C-V-R
- ❑ Chest Pain
- ❑ Short Breath
- ❑ Blood Pressure Problems
- ❑ Irregular Heartbeat
- ❑ Heart Problems
- ❑ Lung Problems/Congestion
- ❑ Varicose Veins
- ❑ Ankle Swelling
- ❑ Stroke

Gastro-Intestinal
- ❑ Poor/Excessive Appetite
- ❑ Excessive Thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver Problems
- ❑ Full Bladder Problems
- ❑ Weight Trouble
- ❑ Abdominal Cramps
- ❑ Gas/Bloating After Meals
- ❑ Heartburn
- ❑ Black/Bloody Stool
- ❑ Colitis

Nervous System
- ❑ Nervous
- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusion/Depression
- ❑ Fainting
- ❑ Convulsions
- ❑ Cold/Tingling Extremities
- ❑ Stress

Male/Female
- ❑ Menstrual Irregularity
- ❑ Menstrual Cramps
- ❑ Vaginal Pain/Infection
- ❑ Breast Pain/Lumps
- ❑ Prostate/Sexual Dysfunction
- ❑ Other Problems
- ❑ _____
- ❑ _____

Musculoskeletal
- ❑ Low Back Pain
- ❑ Pain Between Shoulders
- ❑ Neck Pain
- ❑ Arm Pain
- ❑ Joint Pain/Stiffness
- ❑ Walking Problems
- ❑ Difficulty Chewing/Clicking Jaw
- ❑ General stiffness

Female Only

When was your last period? _____

Are you Pregnant? ❑ Yes ❑ No ❑ Not Sure

Due date: _____

General
- ❑ Fatigue
- ❑ Allergies
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches

Ear, Nose, Throat
- ❑ Vision Problems
- ❑ Dental Problems
- ❑ Sore Throat
- ❑ Ear Aches
- ❑ Hearing Difficulty
- ❑ Stuffed Nose
- ❑ Dry Mouth
- ❑ Vertigo/Dizziness

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FAMILY HEALTH HISTORY

Name: _____ Date: _____

Select all choices that apply to your family (do not include relations by marriage)

	Mother	Father	Siblings	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
If no longer living, please list cause of death								
Arthritis								
Cancer - type								
Depression								
Diabetes								
Headaches								
Heart Attack/Disease								
High Blood Pressure								
Multiple Sclerosis								
Osteoporosis								
Stroke								
Thyroid Disease								

I understand that the information I have provided is current and complete to the best of my knowledge.

_____

Signature (Parent or Guardian if necessary)