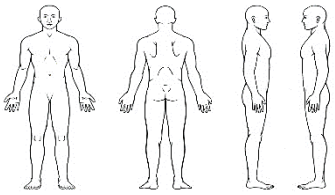
PREMIER
MEDICAL INTEGRATION

History of Illness/Injury/Pain


Please mark your areas of pain

Name: _____ Date: _____

Chief Complaint and it's location: _____

_____

What caused the onset? _____

What makes it better? _____

What makes it worse? _____

Describe the pain: ☐ achy ☐ burning ☐ sharp ☐ dull ☐ stabbing ☐ throbbing ☐ numbness ☐ other: _____

Does the pain radiate? ☐ Yes ☐ No Where? _____

On a scale of 1-10, what would you rate our pain? Please circle 1 2 3 4 5 6 7 8 9 10

How much of your day do you feel the pain? □ All Day □ Half of the day □ Quarter of the day □ Other:_____

What time of the day do you feel it the most? _____

Have you lost work days because of it? ☐ Yes ☐ No How Many? _____

Was it caused by an automobile accident? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No Other: _____

Have you experienced the pain in the past? ☐ Yes ☐ No How long ago? _____

Have you been treated by a chiropractor for this or any other condition? ☐ Yes ☐ No

If yes, by whom: _____ How long ago?_____

Were you helped? ☐ Yes ☐ No Did you follow the doctor's recommendations? ☐ Yes ☐ No

Are you currently being treated by another doctor? ☐ Yes ☐ No If yes, by whom? _____

Why are you being seen? _____

Please list medications you are currently taking, including over-the-counter and prescription medications: _____

_____

_____

	SECONDARY COMPLAINTS	PLEASE DESCRIBE
1.	_____	_____
	On a scale of 1-10, what would you rate your pain?	(Please Circle) 1 2 3 4 5 6 7 8 9 10
2.	_____	_____
	On a scale of 1-10, what would you rate your pain?	(Please Circle) 1 2 3 4 5 6 7 8 9 10
3.	_____	_____
	On a scale of 1-10, what would you rate your pain?	(Please Circle) 1 2 3 4 5 6 7 8 9 10

How do you want us to handle your condition?

☐ Maximum Correction (Correct the cause of the problem, so it doesn't return)

☐ Temporary Relief (Pain relief from symptoms, no correction)

On a scale of 1-10 (10 being the most and 1 being the least):

_____ How committed are you at reaching your maximum health potential?

_____ How important is it for your family to be at their maximum health potential?

_____ How committed are you to preventing arthritis and maximizing your spinal stability?

SYSTEMS REVIEW: Please place an **X** in the blank if you are experiencing NOW, and place a **P** in the blank if you have experienced in the PAST:

_____ Alcoholism
_____ Allergies/Hay Fever
_____ Anxiety
_____ **Arthritis
_____ Asthma/Wheezing
_____ Bed-Wetting
_____ Blood in Unrine/Stool
_____ **Broken/Fractured Bones
_____ **Cancer
_____ Circulatory Problems
_____ Cold Feet/Hands
_____ Confusion
_____ **Congenital Disease
_____ Constipation
_____ Cramping of Legs/Feet
_____ Depression
_____ **Diabetes
_____ Diarrhea
_____ Difficulty Breathing
_____ **Digestive Problems
_____ Dizziness/Fainting/Vertigo
_____ Drug Addiction
_____ Ear Problems/Hearing Disorder
_____ **Eating Disorder
_____ Eye/Vision Problems
_____ Fatigue
_____ **Female Problems
_____ Frequent Sore Throat/Strep
_____ Gall Bladder Problems
_____ Headache
_____ **Heart Problems
_____ Heartburn/Gas
_____ Hiatal Hernia
_____ High/Low Blood Pressure
_____ HIV Positive
_____ Indigestion
_____ Insomnia
_____ Irregular Heartbeat/Palpitations
_____ Irritability
_____ Kidney Stones
_____ Liver Trouble
_____ Loss of Bladder Control
_____ Loss of Memory
_____ Mid Back Pain
_____ Muscle Weakness
_____ Nausea
_____ Neck Pain
_____ Nervousness
_____ Numbness, Tingling Hands/Arms
_____ Numbness, Tingling Legs/Feet
_____ Pacemaker
_____ Pain into Hips/Legs/Feet
_____ Pain into Knee RT LT
_____ Pain into Ribs/Chest
_____ Pain into Shoulder RT LT
_____ **Prostate Problems
_____ Recurrent Bladder Infections
_____ Recurrent Kidney Infections
_____ Recurrent Lung Infections
_____ Seizures/Convulsions
_____ Sexual Dysfunction
_____ **Skin Problems
_____ Stroke
_____ Ulcers
_____ Weakness in Grip RT LT
_____ Other: _____

**** Explain:** _____

WOMEN ONLY:

_____ Currently Pregnant
_____ Excessive Flow
_____ Hot Flashes
_____ Hysterectomy
_____ Irregular Periods
_____ Lumps in Breast
_____ Menstrual Cramps
_____ PMS/Menopause
_____ Other: _____

MEN ONLY:

_____ Difficulty with Urnitation
_____ Erectile Dysfunction
_____ Prostate Trouble
_____ Testicular Cancer
_____ Other: _____
_____

FAMILY HISTORY: Please check those that have affected you or your family. Who? _____

____ Anemia
____ Asthma
____ Cancer
____ Circulatory Problems
____ Developmentally Challenged
____ Diabetes
____ Epilepsy
____ Heart Disease
____ High Blood Pressure
____ Kidney Disease
____ Low Blood Pressure
____ Obesity/Overweight
____ Psychiatric
____ Stroke
____ Tuberculosis
____ Other: _____

SOCIAL HISTORY: Do you smoke? ☐ Yes ☐ No If yes, indicate amount per day: _____

Do you exercise? ☐ Yes ☐ No If yes, describe: _____

Do you drink? (Please check ALL that apply): ☐ Coffee ☐ Tea ☐ Alcoholic Beverages ☐ Soda

Describe regularity of ALL checked: _____

Do you sometimes feel you do not have enough energy to get through the day? ☐ Yes ☐ No

Do you take nutritional supplements? ☐ Yes ☐ No Describe: _____

Are you on any special diet? ☐ Yes ☐ No Describe: _____

Thank you for completing this questionnaire. This information is necessary in evaluating your condition. I authorize the release of any information required, and that my Insurance benefit payments be paid directly to the clinic. Signature states all to be true and correct.

_____ _____
Patient/Guardian Signature Date