ASPEN CLUB
SPORTS MEDICINE INSTITUTE

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ①None ②Light ③Moderate ④Strenuous

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ] lbs.
Feet *Inches*

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*	
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbances
○	○	Dizziness

Past	*Present*	
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	*Present*	
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS

Females Only

○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy
○	○	

Other Health Problems/Issues

○	○
○	○
○	○

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○_____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Do you have a pacemaker? Yes No

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Patient Name _____ **Date** _____

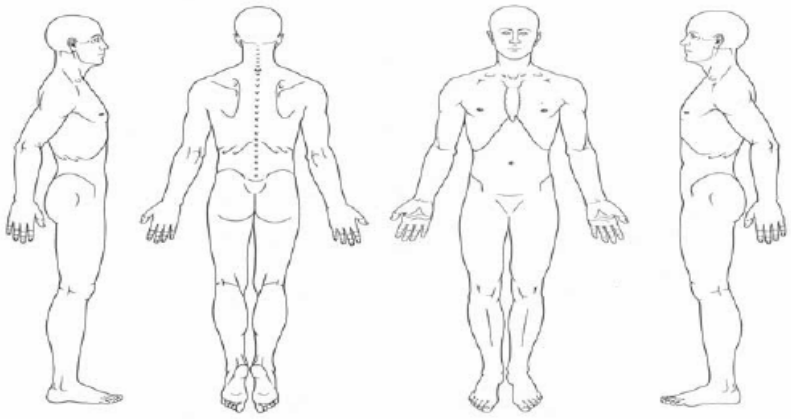
1. When did your symptoms start: _____ **Describe your symptoms and how they began:**

_____

_____

2. How often do you experience your symptoms?
① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?
① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?
① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?
① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?
① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

10. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?
① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

11. What is your occupation?
① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?
① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

12. What do you hope to get from your visit/treatment *(select all that apply):*
① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Patient Signature _____ **Date** _____

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