

WELLNESS FIRST CHIROPRACTIC, PLLC

Dr. Robert S. Kimberlain, DC

PERSONAL AND FAMILY MEDICAL HISTORY

Check <input checked="" type="checkbox"/> symptoms or conditions you currently have, or have had in the past:			
<input type="checkbox"/> Headaches <input type="checkbox"/> Jaw pain <input type="checkbox"/> Neck / shoulder / arm pain <input type="checkbox"/> Upper or mid back pain <input type="checkbox"/> Low back / hip / leg pain <input type="checkbox"/> Wrist/hand pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Ankle/foot pain <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Visual disturbances <input type="checkbox"/> Dizziness <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart attack / Chest pain <input type="checkbox"/> Stroke <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Joint swelling / stiffness <input type="checkbox"/> Arthritis (rheumatoid / other) <input type="checkbox"/> Systemic Lupus <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cancer <input type="checkbox"/> Sciatica	<input type="checkbox"/> Kidney disorders <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Ulcers <input type="checkbox"/> Urinary problems <input type="checkbox"/> Liver / Gall bladder disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Dermatitis / Eczema <input type="checkbox"/> HIV / AIDS <input type="checkbox"/> Concussion <input type="checkbox"/> TB	<input type="checkbox"/> Convulsion <input type="checkbox"/> Diabetes <input type="checkbox"/> Digestion Problems <input type="checkbox"/> Epilepsy <input type="checkbox"/> Heart Problems <input type="checkbox"/> Measles <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Neuritis <input type="checkbox"/> Numbness <input type="checkbox"/> Polio <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Venereal Disease

Yes	No	Do you have any of the following?	Yes	No	Do you have any of the following?
<input type="checkbox"/>	<input type="checkbox"/>	History of cancer?	<input type="checkbox"/>	<input type="checkbox"/>	History of significant trauma?
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss?	<input type="checkbox"/>	<input type="checkbox"/>	Minor trauma in person > 50 years old?
<input type="checkbox"/>	<input type="checkbox"/>	Pain improved with rest?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have osteoporosis (weak bones)?
<input type="checkbox"/>	<input type="checkbox"/>	Are you over 50 years old?	<input type="checkbox"/>	<input type="checkbox"/>	Are you over 70 years old?
<input type="checkbox"/>	<input type="checkbox"/>	Failed to respond to conserv. Care (4-6 weeks)?	<input type="checkbox"/>	<input type="checkbox"/>	History of prolonged use of corticosteroids?
<input type="checkbox"/>	<input type="checkbox"/>	Had spine pain greater than 4 weeks?			
<input type="checkbox"/>	<input type="checkbox"/>	Prolonged use of corticosteroids?	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty controlling your urine?
<input type="checkbox"/>	<input type="checkbox"/>	Intravenous drug use?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have bowel accidents?
<input type="checkbox"/>	<input type="checkbox"/>	Recent urinary, respiratory, or other infection?	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in the groin region?
<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppression medication / condition?	<input type="checkbox"/>	<input type="checkbox"/>	Do your legs give out?

FAMILY HISTORY	NO	YES	If yes, who?	LIST YOUR MEDICATIONS	
Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>		1.	
Cancer	<input type="radio"/>	<input type="radio"/>		2.	
Diabetes	<input type="radio"/>	<input type="radio"/>		3.	
Heart Problems	<input type="radio"/>	<input type="radio"/>		4.	
Back Problems	<input type="radio"/>	<input type="radio"/>		5.	
Lupus	<input type="radio"/>	<input type="radio"/>		6.	
HABITS (How often do you)				LIST ALLERGIES	
Smoke:	0	1/2	1 2 >2 packs/day	1. 4.	
Drink alcohol:	0	1-3	4-7 >7 drinks/week	2. 5.	
Have caffeine:	0	1-3	4-6 >6 cups/day	3. 6.	
Water intake:	0	1-3	4-6 >6 cups/day		
LIST SURGERIES / HOSPITALIZATIONS					
1.			3.		
2.			4.		
WHAT TYPE OF REGULAR EXERCISE DO YOU PERFORM?		<input type="radio"/> None	<input type="radio"/> Light	<input type="radio"/> Moderate	<input type="radio"/> Strenuous
CURRENT OCCUPATIONAL ACTIVITY LEVEL:		<input type="radio"/> None	<input type="radio"/> Light	<input type="radio"/> Moderate	<input type="radio"/> Strenuous
PREVIOUS OCCUPATIONAL HISTORY:		<input type="radio"/> None	<input type="radio"/> Light	<input type="radio"/> Moderate	<input type="radio"/> Strenuous