

SCHILSKY CHIROPRACTIC CENTER

312 Dolphin Drive
Jacksonville, North Carolina 28546
910-347-4033

Dr. Randy M. Schilsky Dr. Roger Roff, Jr. Dr. Brett Whitekettle Dr. Tracy Keefer Dr. Sean Keefer

Proper First Name: _____ Last Name: _____ Middle Initial: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Street Address and Number: _____ City _____ State _____ Zip _____

Mailing Address (if different): _____ Social Security _____

Email Address: _____ Age: _____ Date of Birth: _____

Sex: ___ Male ___ Female Marital Status (Circle One): Married Single Widowed Divorced Number of Children _____

Occupation: _____ Employer: _____

Work Status: full time part time Student: full time part time

Driver's License # _____ State _____ How were you referred to our office? _____

Spouse's Name: _____ Spouse's Occupation: _____

In case of emergency, please contact (include phone): _____

Are today's problems related to: Auto Injury _____ Workman's Compensation _____ Neither _____

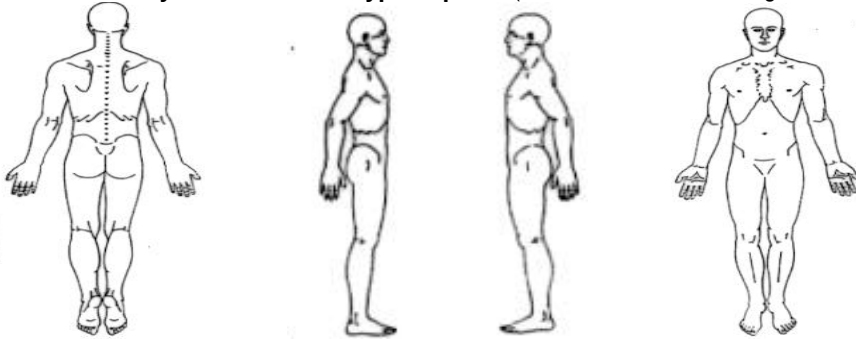
Describe your condition(s) beginning with the most severe . Please rate each condition on a scale of one to 10. (10 being the worst).

1. _____ (/10) 3. _____ (/10) 5. _____ (/10)

2. _____ (/10) 4. _____ (/10) 6. _____ (/10)

3. How often do you experience pain? ___ Constantly (75-100%) ___ Frequently (50-75%) ___ Occasionally (25-50%) ___ Intermittently (1-25%)

4. How would you describe the type of pain? (Please indicate on the diagram below where you have symptoms)



A = Ache
D = Dull
B = Burn
S = Sharp
SH – Shooting
O = Other

5. How are your symptoms changing with time? Getting Worse Staying the Same Getting Better

6. How much has the problem interfered with your work? Not at all A little bit Moderately Quite a bit Extremely

7. How much has the problem interfered with your social activities? Not at all A little bit Moderately Quite a bit Extremely

8. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician ER physician No one
- Orthopedist Massage Therapist Physical Therapist Other: _____

Who: _____ Treatment? _____ Results: _____

9. Who is your family physician? _____

10. How long have you had this problem? _____

11. How do you think your problem began? _____

12. Do you consider this problem to be severe? Yes Yes, at times No

13 a. What aggravates your problem? _____

b. What makes it better? _____

Over please

14. What concerns you the most about your problem; what does it prevent you from doing? _____

15. What is your: Height _____ Weight _____

16. How would you rate your overall Health? Excellent Very Good Good Fair Poor

17. What type of exercise do you do? Strenuous Moderate Light None

18. Family History: Place an (X) if any family member has suffered from:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Cancer | <input type="checkbox"/> ALS | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Gout | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Spinal Disorder | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Migraine |

19. 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	Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Neck Pain
<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains
<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence	<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies	<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders
<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy	<input type="checkbox"/>	<input type="checkbox"/> Hip Pain
<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash	<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain
<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness
<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Tumor
<input type="checkbox"/>	<input type="checkbox"/> Muscular In coordination	<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis
<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

For Females Only Birth Control Pills Hormonal Replacement Pregnancy

20. What activities do you do at work?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

21. What activities do you do outside of work? _____

22. List all prescription medications you are currently taking: _____

23. List all surgical procedures you have had: _____

24. List all of the over-the-counter medications you are currently taking: _____

25. Have you ever been hospitalized? No Yes
if yes, why _____

26. Have you seen a Chiropractor before? No Yes If yes, who? _____

27. Have you had significant past trauma? No Yes

28. Anything else pertinent to your visit today? _____

I hereby authorize Schilsky Chiropractic Center to examine me, including x-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me. First day's fees are due and payable at the time of service. BY SIGNING YOUR NAME BELOW, YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO DR. SCHILSKY'S OFFICE FOR EVALUATION AND TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.

Signature of patient, or of Guardian authorizing care

Date