**Buerker Chiropractic 1660 Tower Street Schenectady, NY 12303**

Have you ever been treated by a chiropractor before?__________
What is the reason for your visit?______________________________
What do you think caused your problem?______________________________
How long have you had your current problem?______________________________
Have you had similar problems in the past?__________ How long ago?____________________
Is there anything that makes your problem **better?**_______________ or makes it **worse?**_______________
Is your problem getting better?__________ Is it getting worse?__________
Is your problem constant?__________ Does it come and go?__________
Does your problem disrupt your sleep?________ Interfere with work?________ Your daily routine?__________
Have you seen any other physicians for this problem?_____ If so, whom?____________________

Physician name Phone #

Have you had x-rays for this problem?_____ If so, where?______________________________
Do you have any other complaints?______________________________

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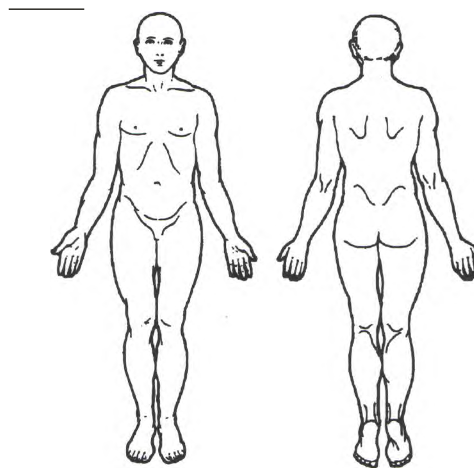
Who is your primary care physician?______________________________

Physician name Phone #

What is the date of your last physical exam?______________________________

Please mark your areas of pain on the figure diagrams below.



**PAIN SCALES**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NECK | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | NO PAIN | | | | | | | | | | WORST PAIN IMAGINABLE |
| LOW BACK | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | NO PAIN | | | | | | | | | | WORST PAIN IMAGINABLE |
| OTHER | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | NO PAIN | | | | | | | | | | WORST PAIN IMAGINABLE |

Patient Name:________________________________________

Have you ever had any surgery?______ Operation and approximate date:________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Have you ever broken any bones?________________________________________________________________

________________________________________________________________________________________________

Have you ever been hospitalized?_____ Please list problem and date:______________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Please list any major illnesses or medical conditions and dates:___________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Please list any medications you are taking including, prescription, over the counter meds, vitamins, etc.

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Please list any known allergies including drugs, seasonal and animal____________________________________

________________________________________________________________________________________________

**Have you ever suffered from the following?**

| | | | | | |
|---|---|---|---|---|---|
| Abnormal weight gain/loss | Y | N | Epilepsy/Seizures | Y | N |
| Anemia | Y | N | Head injury | Y | N |
| Easy Bruising/Bleeding | Y | N | Stroke/TIA | Y | N |
| Diabetes | Y | N | Arthritis | Y | N |
| Thyroid Problems | Y | N | Osteoporosis | Y | N |
| Tuberculosis | Y | N | Anxiety | Y | N |
| Kidney Problems/Stones | Y | N | Depression | Y | N |
| High Blood Pressure | Y | N | Alcohol/Drug Abuse | Y | N |
| Cancer | Y | N | HIV/AIDS | Y | N |
| Visual Difficulties | Y | N | STD's | Y | N |
| Hearing Problems | Y | N | General Fatigue | Y | N |
| Dizziness | Y | N | Skin Problems | Y | N |
| Sinus Problems | Y | N | Eating Disorders | Y | N |
| Swallowing Difficulties | Y | N | Multiple Sclerosis | Y | N |
| Indigestion / Heartburn / Abd Pain | Y | N | Pacemaker | Y | N |
| Excessive Diarrhea/Constipation | Y | N | Polio | Y | N |
| Hernia | Y | N | Prostate Problems | Y | N |
| Gallbladder Problems | Y | N | Ulcers | Y | N |
| Liver Disease/Hepatitis | Y | N | Excessive Thirst/Hunger | Y | N |
| Pancreas Problems | Y | N | Immune Disorders | Y | N |
| Lung/Breathing /Asthma Problems | Y | N | Frequent Urination | Y | N |
| Heart Disease/Circulatory Problem | Y | N | Chest Pain/Angina | Y | N |
| Rheumatic Fever | Y | N | Swelling of Body Parts | Y | N |
| Urinary Problems | Y | N | Cramping of Body Parts | Y | N |
| Headaches | Y | N | Memory Loss/Dementia | Y | N |

**FOR WOMEN ONLY** Date of last menstrual period?____________________ Are You Pregnant?____________

**FOR MEN ONLY** Date of last prostate exam?______________________ Last Known PSA? ____________

______________________________________________________________ ____________________

I certify that the above information is correct to the best of my knowledge.

______________________________________________________________ ____________________

Patient/Parent or guardian signature Date