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Referred by ____________________

Name ______________________ Prefers ______________ DOB ______________ Gender M___ F___

Address ______________________________________ Marital Status - M__ D__ S__ W__

City ______________ State _____ Zip _______ SS# ______________ Spouse's Name ______________

Phone (cell) ______________ (h) ______________ (w) ______________ Children ages __________

Occupation ______________ Employer ______________ E-mail ______________

Do you have a primary care physician? ______________________ address/phone ______________________

CONDITION ONE — Please list problems in the order of their severity.

Describe your symptoms ____

When did your symptoms start? __________ What caused them? ______________ Do you have any numbness? __________

How does it feel? (ache, sharp, burn, etc.) ______________________ Is your condition ___ Improved __ Unchanged ___ Worsening?

What makes it feel better? ______________________ What makes it feel worse? ______________________

How often do your symptoms occur? ______________ Does the pain travel or spread? ______________ Is so where? __________

Have you had similar problems in the past? ______________ Is this condition interfering with __ sleep __ work __ daily routine __ other (______)

Have you seen another physician for this condition? ______________________________

Doctors notes: ____

CONDITION TWO

Describe your symptoms ____

When did your symptoms start? __________ What caused them? ______________ Do you have any numbness? __________

How does it feel? (ache, sharp, burn, etc.) ______________________ Is your condition ___ Improved __ Unchanged ___ Worsening?

What makes it feel better? ______________________ What makes it feel worse? ______________________

How often do your symptoms occur? ______________ Does the pain travel or spread? ______________ Is so where? __________

Have you had similar problems in the past? ______________ Is this condition interfering with __ sleep __ work __ daily routine __ other (______)

Have you seen another physician for this condition? ______________________________

Doctors notes: ____

How would you rate your stress levels? (0= no stress, 10= high stress) ________ Do you exercise? _____ How often? _______ What activity __________

Do you take vitamins/supplements? ________ If so, what kind? ______________________

Are you currently under another physicians care? ______________ If so, what kind? ______________________

Are you currently taking any medications? ______________ If so, what kind? ______________________

Have you had any surgeries? ______________ If so, when/describe ______________________

Do you have any history of significant illness in your family? _______ Please list ______________________

Have you had any accidents/traumas? _____ If so, when/describe ______________________

Have you ever been treated by a chiropractor before? _______ When? ______________________

Do you have a Pace Maker or any other heart condition? ______________________

Signature ______________________________________ Date ______________

Parent/Guardian ______________________________________ Date ______________

SOCIAL HISTORY

Current Weight ________ Have you recently lost or gained weight? _______ Height_________

Mental Work ☐Heavy ☐Moderate ☐Light Hours per day _________

Physical Work ☐Heavy ☐Moderate ☐Light Hours per day _________

Exercise ☐Heavy ☐Moderate ☐Light Hours per week ________ Type______________

Smoking ☐Current ☐Previous Packs per day _______________ No of Years ________

Alcohol Consumption Socially/None ________ Moderate ________ Heavy _________

MARK THE AREA OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:

Aches ^^^^^ Numbness oooo Pins/Needles …… Stabbling /////

MARK AN 'X' ON THE LINES:

Condition #1

How bad are your symptoms now? How bad have they been in the past?

_______________________________________ _______________________________________

None Most Severe None Most Severe

Condition#2

How bad are your symptoms now? How bad have they been in the past?

_______________________________________ _______________________________________

None Most Severe None Most Severe

Patient Name _______________________________________ Number ______________Date __________

REVIEW OF SYSTEM

General	Yes	No
Are you in good general health	☐Y	☐N
Recent weight change	☐Y	☐N
Fever	☐Y	☐N
Fatigue	☐Y	☐N
Are you out of shape	☐Y	☐N
Eyes and Vision		
Eye disease or injury	☐Y	☐N
Wear glasses / contact lenses	☐Y	☐N
Blurred or double vision	☐Y	☐N
Ears, nose, and throat		
Hearing loss	☐Y	☐N
Ringing in the ears	☐Y	☐N
Earaches or drainage	☐Y	☐N
Sinus problems	☐Y	☐N
Swollen glands in neck	☐Y	☐N
Nose bleeds	☐Y	☐N
Bleeding gums	☐Y	☐N
Sore throat or voice change	☐Y	☐N
Heart Cardiovascular		
Do you have a pacemaker	☐Y	☐N
Swelling of feet, ankles, hands	☐Y	☐N
Heart trouble	☐Y	☐N
Chest pains	☐Y	☐N
Sudden heartbeat changes	☐Y	☐N
Respiratory		
Spitting up blood	☐Y	☐N
Frequent coughing	☐Y	☐N
Shortness of breath	☐Y	☐N
Asthma or wheezing	☐Y	☐N
Gastrointestinal		
Frequent diarrhea	☐Y	☐N
Painful bowel movements	☐Y	☐N
Blood in stool	☐Y	☐N
Loss of appetite	☐Y	☐N
Loss of Bowel/Bladder control	☐Y	☐N
Stomach pain	☐Y	☐N
Nausea or vomiting	☐Y	☐N
Genitourinary		
Burning or painful urination	☐Y	☐N
Irregular periods	☐Y	☐N
Kidney stones	☐Y	☐N
Frequent urination	☐Y	☐N
Incontinence or dribbling	☐Y	☐N
Blood in urine	☐Y	☐N

Musculosketelal	Yes	No
Muscle pain or cramps	☐Y	☐N
Joint swelling	☐Y	☐N
Weakness of muscles/joints	☐Y	☐N
Cold hands or feet	☐Y	☐N
One leg shorter than the other	☐Y	☐N
Difficulty in walking	☐Y	☐N
Foot/Ankle/Knee/Hip pain	☐Y	☐N
Orthotics	☐Y	☐N
Skin and breasts		
Rash or itching	☐Y	☐N
Change in skin color	☐Y	☐N
Breast lump	☐Y	☐N
Breast pain	☐Y	☐N
Breast discharge	☐Y	☐N
Neurological		
Paralysis	☐Y	☐N
Frequent/recurrent headache	☐Y	☐N
Light headed or dizzy	☐Y	☐N
Head Injury	☐Y	☐N
Stroke	☐Y	☐N
Tremors	☐Y	☐N
Numbness or tingling	☐Y	☐N
Convulsions or seizures	☐Y	☐N
Endocrine		
Dry skin	☐Y	☐N
Heat/cold intolerance	☐Y	☐N
Glandular/hormone problem	☐Y	☐N
Change in hat/glove size	☐Y	☐N
Thyroid disease	☐Y	☐N
Diabetes	☐Y	☐N
Excessive thirst/urination	☐Y	☐N
Hematologic/Lymphatic		
Anemia	☐Y	☐N
Transfusion	☐Y	☐N
Swollen glands	☐Y	☐N
Psychiatric		
Memory loss or confusion	☐Y	☐N
Sleep problems	☐Y	☐N
Depression	☐Y	☐N
Anxiety	☐Y	☐N

Last Date of Menstrual Cycle______________

Last Prostate Exam ______________________

Additional Explanation if required ____

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Dr. Matthew Schmid, DC 7116-A Six Forks Rd, Raleigh NC, 27615

Patient Name_______________________________Chart#_____________Date________________DOB______________