

/ ROXBURY SPINE & WELLNESS CLINIC /

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LAST NAME _____ FIRST NAME _____ MIDDLE _____
 ADDRESS _____ SS# _____ BIRTHDATE _____ AGE _____
 CITY _____ STATE _____ ZIP _____ DL# _____ E-MAIL _____
 OCCUPATION _____ SPOUSE _____ KIDS NAMES & AGES _____
 EMPLOYER _____ SPOUSE'S OCCUPATION _____
 PHONE # _____ WORK _____ EMPLOYER _____
 CELL/PGR _____ HOW DID YOU HEAR ABOUT US? _____
 INSURANCE CO. _____ POLICY # _____ CONTACT _____

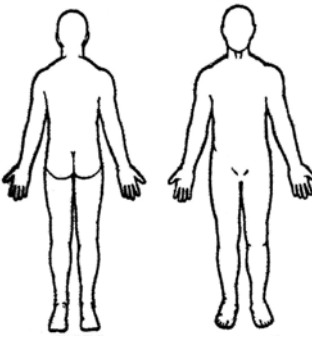
What is your major complaint? _____ How intense is it on a scale of 1-10? (1-least, 10 worst) _____
 When did this condition first develop? _____ How often does it bother you? 100%-75%-50%-25% of the time _____
 Is this the first time? _____ What caused this condition? _____
 What makes it worse? _____ Has the problem been getting worse, better, or staying the same? _____
 What have you done to help yourself? _____ Other Doctors seen and recommendations: _____
 Other complaints: _____

From birth to present, please list by date and describe:

Please mark if you have you EVER had any of the following health issues:

- | | | |
|---|--|---|
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Sore Muscles | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Shoulder Problems | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Numbness in Hands | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Low Back Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor Digestion |
| <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Numbness in Legs | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Loss of Feeling | <input type="checkbox"/> Depression | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Stiff Joints | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Ear Pain/Noises | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Restricts Daily Activities | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Restricts Exercise | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Blood Pressure Hi/Lo |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tiredness/Fatigue | <input type="checkbox"/> Frequent Colds |

Circle ALL areas of complaint on diagram.



How does it feel?

- Sharp
- Dull
- Stiffness
- Aching
- Tingling
- Numbness
- Burning
- Constant
- Comes & Goes
- Other

This is a new / old condition. I have / haven't had care for it before.
 If previous care, what was done? _____ Car Accidents _____

Name of Doctors: _____

Have you ever had surgery or been hospitalized? Y / N _____

List surgeries: _____ Falls/injuries (including Sports) _____

Have you EVER had chiropractic care before? Y / N _____

Name of Doctor _____

Was it a good experience? Y / N _____

Last time you had spinal x-rays or other x-rays: _____ Other _____

Medications you now take: _____

Please list any additional information that maybe important to your care:

Please feel free to fax or email your paperwork
appointment@roxburyclinic.com - Fax 206-937-4643