Staci Talan, D.C., I.D.E., Q.M.E.

Chiropractor * Industrial Disability Examiner (IDE) * Qualified Medical Examiner (QME)

39809 Paseo Padre Parkway, Fremont, CA 94538 * TEL: 510-657-1234 * FAX: 510-657-1233

Chief complaint or reason for today's visit?____________________________________

How long have you had this condition?____________________ Date of Onset?____________

Have you had this condition before?______________ If yes, when?____________________

Is the condition related to Work ( ) Auto ( ) Date of Accident:________ Have you lost days at work?______

What doctors have seen you for this condition?__________________ Diagnosis____________

Provide dates of last: Xray:_______ Physical Examination:________ Blood Test:______________

Name of primary treating physician:____

Height____________ Weight____________ Age__________ Occupation____________

Do you smoke? ☐ no ☐ yes If, yes how many packs/day________ Do you drink Alcohol? ☐ no ☐ yes

If yes how many drinks a day_______ Do you drink coffee? ☐ no ☐ yes If yes how many cups a day______

Have you seen a Chiropractor? Yes ( ) No ( ) Who:____________________ Did it help? Yes ( ) No ( )

PROBLEM AREA #1

The pain is located __________________ The pain started __________ ☐ days ago ________

☐ weeks ago __________ ☐ months ago ____________ ☐ years ago __________________

On a scale of 1-10 rate your pain No pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

How would you describe the pain ☐ dull, achy ☐ sharp, stabbing ☐ burning ☐ pins and needles

Do you consider this problem to be severe? ☐ yes ☐ yes, at times ☐ no

The pain is made *better* by____

The pain is made *worse* by____

The pain is (as far as timing is concerned: i.e: comes & goes, constant etc.)____________________

☐ There is radiating pain, tingling, or numbness into__________________________________

How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem intefered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

ADDITIONAL AREA #2

The pain is located____

The pain started ____ ☐ days ago _______☐ weeks ago ______☐ months ago _____ ☐ years ago

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On a scale of 1-10 rate your pain No pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

How would you describe the pain ☐ dull, achy ☐ sharp, stabbing ☐ burning ☐ pins and needles

The pain is made *better* by ____________________

The pain is made *worse* by ____________________

The pain is (as far as timing is concerned: i.e: comes & goes, constant etc.) ____________________

☐ There is radiating pain, tingling, or numbness into ____________________

ADDITIONAL AREA #3

The pain is located ____________________ The pain started ____________________

☐ days ago ______________ ☐ weeks ago ______________ ☐ months ago ____________ ☐ years ago ________

On a scale of 1-10 rate your pain No pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

How would you describe the pain ☐ dull, achy ☐ sharp, stabbing ☐ burning ☐ pins and needles

The pain is made *better* by ____________________

The pain is made *worse* by ____________________

The pain is (as far as timing is concerned: i.e: comes & goes, constant etc.) ____________________

☐ There is radiating pain, tingling, or numbness info ____________________

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

What type of exercise do you do? ☐ Strenuous ☐ Moderate ☐ Light ☐ None

Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus

☐ Heart Problems ☐ Cancer ☐ ALS

List all prescription medications you are currently taking: ____________________

List all supplements, vitamins and herbs you are currently taking: ____________________

List all surgical procedures you have had: ____________________

What activities do you do at work?

☐ Sit	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Stand	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Computer Work	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ On the phone	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Light Labor	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Heavy Labor	☐ Most of the day	☐ Half of the day	☐ A little of the day

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What activities do you do outside of work? ____

Have you ever been hospitalized? ____

Have you had a significant trauma in the past? ____

Anything else pertinent to your visit today? ____

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		
☐ ☐ Headaches	☐ ☐ High Blood Pressure	☐ ☐ Diabetes
☐ ☐ Neck Pain	☐ ☐ Heart Attack	☐ ☐ Excessive Thirst
☐ ☐ Upper Back Pain	☐ ☐ Chest Pain	☐ ☐ Frequent Urination
☐ ☐ Mid Back Pain	☐ ☐ Stroke	☐ ☐ Smoking/Tobacco Use
☐ ☐ Low Back Pain	☐ ☐ Angina	☐ ☐ Drug/Alcohol Use
☐ ☐ Shoulder Pain	☐ ☐ Kidney Disorders	☐ ☐ Depression
☐ ☐ Elbow/Upper Arm Pain	☐ ☐ Bladder Infection	☐ ☐ Allergies
☐ ☐ Wrist Pain	☐ ☐ Painful Urination	☐ ☐ Systemic Lupus
☐ ☐ Hand Pain	☐ ☐ Loss of Bladder Control	☐ ☐ Epilepsy
☐ ☐ Hip Pain	☐ ☐ Prostate Problems	☐ ☐ Dermatitis/Eczema/Rash
☐ ☐ Upper Leg Pain	☐ ☐ Abnormal Wt. Gain/Loss	☐ ☐ HIV/AIDS
☐ ☐ Knee Pain	☐ ☐ Loss Of Appetite	☐ ☐ Abdominal Pain
☐ ☐ Ankle/Foot Pain	☐ ☐ Ulcers	☐ ☐ Hepatitis
☐ ☐ Jaw Pain	☐ ☐ Liver/Gall Bladder Cond	☐ ☐ General Fatigue
☐ ☐ Joint Pain/Stiffness	☐ ☐ Thyroid Disorders	☐ ☐ Muscular Incoordination
☐ ☐ Arthritis	☐ ☐ Visual Disturbances	☐ ☐ Dizziness
☐ ☐ Chronic Sinusitis	☐ ☐ Other:______________	

For female use:

☐ ☐ Birth Control Pills	☐ ☐ Hormonal Replacement	☐ ☐ Pregnancy: #:______

Patient Signature:_______________________________________ **Date:** __________________________________