MJB Wellness Center

3428 Park Avenue, Wantagh NY 11793
516-697-7109

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*Last Name*_____ *First Name*_____ *DOB*_____

*Address*_____ *City*_____ *State*_____ *Zip*_____

*Phone*_____ *Cell*_____ *Email*_____

*Occupation*_____ *Employer*_____

Have you been to a doctor for this problem? Y N

Who/where?

_____

_____

Doctor Diagnosis _____

Are you currently under the care of Chiropractic? Y N Physical Therapy? Y N

Pain Management? Y N Any other treatment not mentioned here? Y N

If yes please explain

_____

_____

_____

_____

What brings you to our office?

Primary Complaint

_____

_____

_____

Date Car Accident _____ *Date first Symptom appeared* _____

Did it begin _____ *Gradual* _____*Sudden* _____*Progressive over time*

*What makes symptoms increase?*_____ *What relieves symptoms?*_____

Type of pain _____*Sharp* _____*Dull* _____*Burn*_____ *Throbbing*

Does the pain radiate? Y N _____*Arm* _____*Leg* _____ *Does not radiate*

Do you have numbness or tingling? Y N How often _____*100%* _____*75%*_____ *50%*_____ *25%*_____ *10%*

Please rate intensity of symptoms of a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

What time of day is the pain worse? _____ *Morning* _____ *Afternoon* _____ *Evening* _____ *Middle of the night*

Secondary Complaint

Date when symptom appeared_____

Did it begin _____Gradual _____ Sudden _____ Progressive over time

What makes symptoms increase? _____ What relieves symptoms? _____

Type of pain _____ Sharp _____ Dull _____ Ache _____Throb

Does the pain radiate? Y N _____ Arm _____Leg _____ Does not radiate

Do you have numbness or tingling? Y N How often _____ 100% _____75% _____50% _____25% _____10%

Please rate intensity of symptoms on a scale of 1-10(1 being not symptoms, 10 being extreme _____

Health Questionnaire

Do you smoke? Y N If yes how may packs per week? _____ Have you smoked in the past? Y N Quit date? ____

Birth Control? Y N Have you taken in the past? Y N Are you pregnant? Y N

Do you consume alcohol? Y N If yes how many drinks per week? Caffeine? Y N how much per day? _____

Do you exercise? Y N If yes how mny t time per week? _____

Do you have a high stress level? Y N If yes please elaborate_____

Please list any medications and reason you are on?

_____

_____

_____

_____

When was the date of your last physical? _____

Are you on Blood Thinners? Y N Do you use a pacemaker? Y N

Past/Current Symptoms Conditions (Please put P for Past and C for Current)

_____ High Blood Pressure _____Respiratory_____ Kidney/bladder problems _____ Allergies _____Asthma

_____Skin Conditions _____Diabetes/Hypoglycemia _____ Stroke _____Headaches _____ Migraines _____Arthritis

____ Digestive Issues _____ Heart Conditions ____ Excessive weight loss/gain ____Scoliosis ____Dizziness ____ Cancer

___Swelling/stiffness in joints ___Abnormal fatigue ____Neck pain ____ Upper back pain _____ Low back pain___

PATIENT SIGNATURE_____DATE_____