Love Chiropractic Center
801 S 48th Street
Lincoln, NE 68510
Ph: 402-484-5353 Fax: 402-484-5406

Patient Information

Full Name: _____ Birthday: _____ Date: _____

SSN: _____ Sex: O M O F Marital Status: O Yes O No

Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ Cell #: _____

Dominant Hand: _____

Employer Information

Employed: O Full Time O Part Time O Unemployed Employer: _____

Employer Address: _____

Employer City: _____ State: _____ Zip: _____

Occupation: _____ Work Duties: _____

Complaint Information

Purpose of Visit: _____ When did this condition begin? _____

What caused this condition? _____

Frequency: O Always O Hourly O Daily O Occasionally

Interferes with Activities: O Yes O No Affected Sleep: O Yes O No Missed Work: O Yes O No

Does the discomfort radiate/travel? O Yes O No

Does it worsen: O Yes O No Explain: _____

Weather Affects It: O Yes O No Explain: _____

What aggravates the condition? _____

What helps the condition? _____

Describe the quality of discomfort: _____

Have you received treatment for this? O Yes O No Have you had recent X-Rays? O Yes O No

Has this concern become: O Worse O Better O Stayed the Same

History

Last Physical Exam: _____ Primary Physician: _____

Health Conditions: _____

Previous Chiropractic Care: O Yes O No Date: _____ Explain: _____

Broken Bones: O Yes O No Explain: _____

Surgery: O Yes O No Explain: _____

Hospitalized: O Yes O No Explain: _____

Auto Accident: O Yes O No Explain: _____

Health Checklist

O Allergies	O Alcoholism	O Anemia	O Arteriosclerosis
O Arthritis	O Asthma	O Back Pain	O Breast Lump
O Bronchitis	O Bruise Easily	O Cancer	O Chest Pain
O Cold Extremities	O Constipation	O Cramps	O Depression
O Diabetes	O Digestion Problems	O Dizziness	O Excessive Menstruation
O Eye Pain or difficulties	O Fatigue	O Frequent Urination	O Headache
O Hemorrhoids	O High Blood Pressure	O Hot Flashes	O Irregular Heart Beat
O Irregular Menstrual Cycle	O Kidney Infection	O Kidney Stones	O Loss of Memory
O Loss of Balance	O Loss of Smell	O Loss of Taste	O Nosebleeds
O Pacemaker	O Polio	O Poor Posture	O Prostate Trouble
O Sciatica	O Shortness of Breath	O Spinal Curvatures	O Sinus Infection
O Insomnia	O Swollen Joints	O Stroke	O Swelling of Ankles
O Ulcers	O Thyroid Condition	O Tuberculosis	O Varicose Veins

O Other: _____

Patient Signature: _____ Date: _____

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PERSONAL HISTORY

OFTEN= O SOMETIMES=S NEVER=N

_____Vigorous Exercise
_____Moderate Exercise
_____Alcohol Use
_____Drug Use
_____Tobacco Use
_____Caffeine

_____High Stress Activity
_____Family Pressures
_____Financial Pressures
_____Other Mental Stressors
_____Other (please specify)_____
_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of family members. Please leave blank those that do not apply. Please circle your answers if your relative lives around this locality, as some conditions are affected by climate.

CONDITION	FATHER Age( )	MOTHER Age ( )	SPOUSE Age( )	BROTHER(S) Age( )Age( )	SISTER(S) Age( )Age( )	CHILDREN Age( )Age( )Age(
Arthritis						
Asthma						
Back Pain						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
Hypertension						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraines						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any family members are deceased, please list their age at death and cause:_____
_____

Patient Signature_____Date_____

Patient Symptoms ACCOUNT #_____

- Please place a checkmark before any condition that bothers you NOW.
- Circle any condition which as been a problem in the PAST (whether it bothers you now or not).
- Also indicate how long it has been a symptom.

HEAD
- ☐ HEADACHE
- ☐ LIGHT-HEADEDNESS
- ☐ FAINTING
- ☐ PAIN IN EYES
- ☐ LIGHT BOTHERS EYES
- ☐ LOSS OF SMELL
- ☐ LOSS OF TASTE
- ☐ DIZZINESS
- ☐ LOSS OF HEARING
- ☐ PAIN IN EARS
- ☐ RINGING IN EARS

NECK
- ☐ PAIN IN NECK
- ☐ NECK PAIN WITH MOVEMENT
- ☐ MUSCLES SPASMS IN NECK
- ☐ GRINDING SOUNDS IN NECK
- ☐ ARTHRITIS IN NECK
- ☐ PINCHED NERVE IN NECK

SHOULDERS
- ☐ PAIN IN RIGHT SHOULDER
- ☐ PAIN IN LEFT SHOULDER
- ☐ PAIN ACROSS SHOULDERS
- ☐ TENSION IN SHOULDERS

ARMS, FOREARMS & HANDS
- ☐ PAIN IN RIGHT UPPER ARM
- ☐ PAIN IN LEFT UPPER ARM
- ☐ PAIN IN RIGHT FOREARM
- ☐ PAIN IN LEFT FOREARM
- ☐ PAIN IN RIGHT WRIST
- ☐ PAIN IN LEFT WRIST
- ☐ PAIN IN RIGHT HAND
- ☐ PAIN IN LEFT HAND
- ☐ PAIN IN RIGHT FINGERS
- ☐ PAIN IN LEFT FINGERS
- ☐ SENSATION OF PINS AND NEEDLES IN RIGHT ARM
- ☐ SENSATION OF PINS AND NEEDLES IN LEFT ARM
- ☐ HANDS COLD
- ☐ SWOLLEN JOINTS IN RIGHT FINGERS
- ☐ SWOLLEN JOINTS IN LEFT FINGERS
- ☐ SORE JOINTS IN RIGHT FINGERS
- ☐ SORE JOINTS IN LEFT FINGERS
- ☐ LOSS OF GRIP STRENGTH IN RIGHT HAND
- ☐ LOSS OF GRIP STRENGTH IN LEFT HAND

MID BACK
- ☐ MID-BACK PAIN
- ☐ PAIN BETWEEN SHOULDER BLADES
- ☐ Muscle spasms

CHEST
- ☐ CHEST PAIN
- ☐ SHORTNESS OF BREATH
- ☐ PAIN AROUND RIGHT RIBS
- ☐ PAIN AROUND LEFT RIBS
- ☐ PAIN AROUND ALL RIBS

ABDOMEN
- ☐ NERVOUS STOMACH
- ☐ NAUSEA
- ☐ GAS
- ☐ CONSTIPATION
- ☐ DIARRHEA

WOMEN ONLY
- ☐ MENSTRUAL PAIN
- ☐ CRAMPING
- ☐ IRREGULARITY

LOW BACK
- ☐ LOW BACK PAIN
- ☐ MUSCLE SPASMS
- ☐ ARTHRITIS IN LOW BACK

HIPS, THIGHS, KNEES, LEGS, ANKLES & FEET
- ☐ PAIN IN RIGHT BUTTOCKS
- ☐ PAIN IN LEFT BUTTOCKS
- ☐ PAIN IN RIGHT HIP JOINT
- ☐ PAIN IN LEFT HIP JOINT
- ☐ PAIN DOWN RIGHT LEG
- ☐ PAIN DOWN LEFT LEG
- ☐ PAIN IN RIGHT ANKLE
- ☐ PAIN IN LEFT ANKLE
- ☐ RIGHT KNEE PAIN
- ☐ LEFT KNEE PAIN
- ☐ PAIN IN RIGHT FOOT
- ☐ PAIN IN LEFT FOOT
- ☐ LEG CRAMPS
- ☐ SENSATIONS OF PINS & NEEDLES IN RIGHT LEG
- ☐ SENSATION OF PINS & NEEDLES IN LEFT LEG
- ☐ RIGHT FOOT FEELS COLD
- ☐ LEFT FOOT FEELS COLD
- ☐ CRAMPS IN RIGHT FOOT
- ☐ CRAMPS IN LEFT FOOT
- ☐ SWOLLEN RIGHT ANKLE OR FOOT
- ☐ SWOLLEN LEFT ANKLE OR FOOT
- ☐ PAINFUL JOINTS IN RIGHT TOES
- ☐ PAINFUL JOINTS IN LEFT TOES

GENERAL
- ☐ NERVOUSNESS
- ☐ IRRITABLE
- ☐ DEPRESSED
- ☐ FATIGUE
- ☐ LOSS OF SLEEP
- ☐ LOSS OF WEIGHT

Other: _____

Patient Signature: _____ Date: _____