

Maple Valley Chiropractic and Massage
23220 Maple Valley Black Diamond Rd SE, Ste 13, Maple Valley, WA 98038
Ph: 425-432-1449 Fax: 425-432-9910

Acct # _____ Date _____ Patient Name _____
Birthdate _____ Age _____ Sex _____ Marital Status: M S W D Referred By _____
Address _____ City, State _____ Zip code _____
Phone: Home _____ Cell _____ Work _____
Occupation _____ Employer _____ Handedness: Left Right

Major Complaints:

| | |
|----------|----------|
| A) _____ | D) _____ |
| _____ | _____ |
| B) _____ | E) _____ |
| _____ | _____ |
| C) _____ | F) _____ |
| _____ | _____ |

Medications: _____
Surgeries: _____

1. Which of your major complaints listed above bother you the most? (Check one or more) A B C D E F
2. How long have you had this complaint(s)? _____

3. Prior to the problem beginning, did you ever have a problem that was the same or similar? _____

4. Did it appear Slowly Immediately?
5. Does anyone else in your family have this problem or a similar one? _____

6. How often does it bother you now? _____
7. When it is at its worst, how does it feel? _____
8. When it is at its worst, how does it interfere with your normal daily activities? _____

9. Does this problem reduce your productivity or effectiveness regarding your work? _____

10. Does it create any problems in your relationships? Yes No
If yes, how? _____

Patient Name _____ Birthdate _____

11. What have you done to aggravate the problem and/or what have you failed to do that would have helped get rid of it? _____

12. If your problem was left unhandled for five years, how do you think it would affect you? _____

13. Are you committed to getting rid of not only your symptom(s) but what has caused it, even if it requires a change in your life-style? Yes No

14. Have you received chiropractic care in the past? Yes No If yes, when were you last adjusted? _____

15. (If children) Tell me about your children: _____

Auto Accident: _____

PI: Seatbelt Yes No Head Position: Straight Ahead Rotated _____

MPH at Impact _____ Amt. Damage to Vehicle _____ Ft. of Acceleration _____

Kind of Car: Theirs _____ Others _____ Position of Head Rest _____