

ActiveCare Rehabilitation and Chiropractic, PC

Dr. Michael A. Speesler

Board Certified Chiropractor

Patient Information

Name: S.S. # Marital Status: S M W D

Address: City: State: Zip:

Sex: M or F D/O/B: Occupation:

Cell Phone: Home Phone: Other:

E-mail:

Emergency Contact: Emergency Contact Phone:

Allergies to Medications:

Have you had Surgeries? If yes, please list with dates:

Do you have any other health condition? Please List:

How would you rate your pain? 0-10 (10 being the most painful)

Are you currently taking any Medications, Over the Counter Medications or Vitamins?

If yes, please list:

Do you take recreational drugs? Yes or No If yes, please list:

Do you drink alcohol? Yes or No If yes, how often?

Do you smoke cigarettes? Yes or No If yes, how often?

Are you pregnant? Y or N

Have you ever had Chiropractic Care? Yes or No Doctor's Name:

Primary Care Physician: Primary Care phone number:

Area (s) of Complaint:

Are you currently treating with another physician for this problem?

Did you have an X-Ray and/ or MRI for this problem? Where:

Do you have any difficulty with:

Lifting Reaching Bending Turning Sitting Squatting Standing Pushing Walking Cough/Sneezing Stair-climbing Other:

Does your condition interfere with: Sleep Work Daily Activities Other:

Check any symptoms you have noticed:

Headache Wrist Pain Sleeping Problems Light Sensitivity Chest Pain Dizziness Pins and Needles in he arms or legs Nervousness Loss of Memory Double Vision Neck Pain Head seems Heavy Fatigue Loss of Balance Upset Stomach Back Pain Numbness in Fingers Numbness in Toes Fever Cold Hands Knee Pain Tension Depression Irritability Cold Feet Shoulder Pain Ringing in ears Cramps Sinus problems Loss of Taste Diarrhea Constipation Vomiting Nausea Difficulty breathing

OTHER:

Health History and Family history: please indicate [self (s) mother (m) or father (f)]

High Blood Pressure Cardiovascular Arthritis Sinus Problems Anemia Diabetes Digestive Disorder Seizures Back Ache Headache Depression Cancer Stroke Asthma Neurological Conditions

OTHER:

Patient Signature: Date: