Moua-Lor Chiropractic & Acupuncture, P.A.
1819 Lowry Ave North, Minneapolis, MN 55411
Phone: (612) 529-0202 Fax: (612) 521-1445

Patient name: _____DOB: _____Date of Injury: _____

CHIEF COMPLAINTS:

Where are you hurting? _____

_____

Please describe how you got hurt? (Example: car collision, work injury, slip and fall, or other)

_____

_____

_____

_____

_____

Pain scale: (circle your pain number)

0 | 1 2 3 | 4 5 | 6 7 | 8 9 | 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Very Severe Pain | Worst Possible Pain

Please describe your pain:

Circle your pain: constant, comes and goes, getting better/worse, or staying the same.

Circle your pain: dull aching, sharp, stiff, stabbing, burning, tight, numbness, inflamed, or tingling.

What makes the condition better?

- ☐ Take prescribed medications
- ☐ Massage
- ☐ Take OTC (over-the-counter) medications
- ☐ Other: _____

What makes the condition worse?

- ☐ Standing ☐ Bending
- ☐ Sitting ☐ Lifting
- ☐ Lying ☐ Twisting
- ☐ Other _____

PAST MEDICAL HISTORY:

1. Have you ever seen a chiropractor before? ☐ No ☐ Yes If yes, when?_____
   Doctor's name and location? _____
   _____
   For what condition? _____
2. Have you seen a medical doctor for this condition? ☐ No ☐ Yes If yes, when?_____
   Doctor's name and location?_____
   _____

Moua-Lor Chiropractic & Acupuncture, P.A.
1819 Lowry Ave North, Mpls, MN 55411
Phone: (612) 529-0202 Fax: (612) 521-1445

Patient name: _____DOB: _____DOI: _____

PAST MEDICAL HISTORY (cont.):

2. Do you have a family doctor? ☐ No ☐ Yes
   Doctor name and address _____
   Reason(s): diabetes, high blood pressure, other: _____
3. Have you been hospitalized in the past? ☐ No ☐ Yes If yes, when? _____
   Hospital name and location? _____
   _____
   Reason for hospitalization? _____
4. Allergies? ☐ No ☐ Yes If yes, explain_____
5. Have you been in a car accident before? ☐ No ☐ Yes If yes, when? _____
   Was anything injured? ☐ No ☐ Yes If yes, what? _____
   How was it treated? _____
   Results of treatment: (complications, complete recovery) _____
6. Do you have any broken bones? ☐ No ☐ Yes If yes, where? _____

SOCIAL HEALTH HISTORY:

.

7. Are you a smoker? ☐ No ☐ Yes If so, how many packs per day? _____
8. Do you consume caffeine? ☐ No ☐ Yes If so, how much per day? _____
9. Do you consume alcohol? ☐ No ☐ Yes If so, how many glasses per day? _____
   How many glasses per week? _____
10. Do you exercise? ☐ No ☐ Yes If yes, what? _____
11. Do you participate in any recreational activities (hobbies)? ☐ No ☐ Yes If so, what kind?_____
12. Are you pregnant or is there any possibility that you may be pregnant? ☐ No ☐ Yes
    If so, how many days, weeks, or months? _____

FAMILY HEALTH HISTORY:

Health Status: (If deceased, from what?)

Father:_____
Mother: _____
Sisters: _____ How many? _____
Brothers: _____ How many? _____
Children: _____How many? _____

_____ _____/_____/_____

(Patient or other legally authorized person signature) (Date)