



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

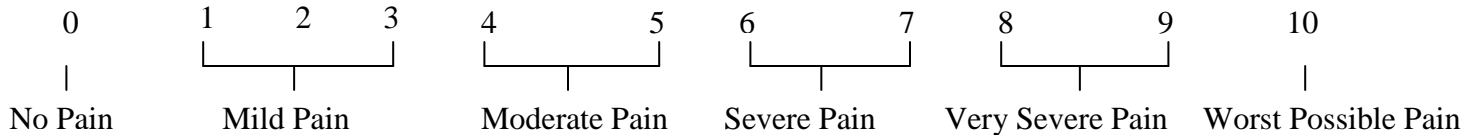
Patient name: _____ DOB: _____ Date of Injury: _____

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)



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:

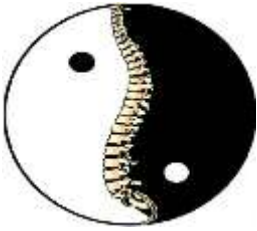
1. Have you ever seen a chiropractor before? No Yes If yes, when? _____

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? _____



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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)