**SNIDER CHIROPRACTIC CENTER**
**346 Merrimon Ave**
**Asheville N.C. 28801**
**828-253-9856**
**Dr. Stephen A Snider**
**www.Sniderchirocenter.com**

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Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Cell Phone: _____-_____-_____ Work Phone: _____-_____-_____

Email Address: _____ Place of employment :_____

Date of Birth: _____Age:____Social Security #: _____-_____-_____ Gender: Male - Female

□ Single □ Married □ Divorced □ Widowed

How did you find our office?_____

How would you like appointment reminders: □ E-mail

□ Text Message ; what is your cell phone provider_____

Preference of Communication: □ Phone call □ Text message □ E-mail

List any **Allergies**:

□ Animals □ Aspirin □ Bees □Chocolate □ Dairy □ Dust □ Eggs □ Latex □ Molds □ Penicillin □ Ragweed/Pollen

□ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye □Other:_____

Reaction(s):_____

List any **Surgeries**:

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □Wrist □ Other: _____

List **ALL Past Medical History** conditions:

□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain □ Depression

□ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain

□ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems □ Hepatitis □ High Blood Pressure

□ Hip Pain □ HIV □ Jaw Pain □ Joint Stiffness □ Knee Pain □ Leg Pain □ Menstrual Problems □ Mid-Back Pain

□Minor Heart Problem □ Multiple Sclerosis □ Neck Pain □ Neurological Problems □ Pacemaker □ Parkinson's

□ Polio □Prostate Problems □ Shoulder Pain □ Significant □Weight Change □ Spinal Cord Injury □ Sprain/Strain

□ Stroke/Heart Attack □ Thyroid Other:

_____

List Type of **Medications** you are taking:

□ Anxiety □ Muscle Relaxors □ Pain Killers □ Insulin □ Birth control □ Cardiovascular □ Allergy □ Seizure

Other: _____

List your **Family History**:

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy □ Genetic Spinal Condition

□ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Parkinson's □ Polio

□ Prostate Problems □ Stroke/Heart Attack □ Other: _____

Have you had any auto or other accidents? □ No □ Yes

Describe: _____

Occupation: _____

Date of last physical examination: _____ Do you smoke? □ No □ Yes

Do you drink alcohol? □ No □Yes - how many per day? _____

Do you drink caffeine? □ No □ Yes - how many per day? _____

Do you exercise? □ No □ Yes (what forms and how often): _____

Do you have problems sleeping? □ No □ Yes; please explain:

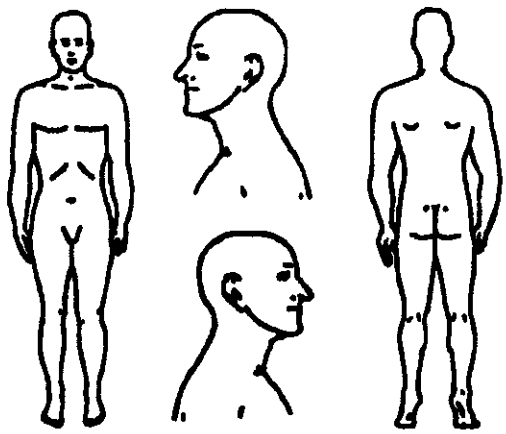
_____

_____

Have You ever had Chiropractic care? Yes_____ No_____ When?_____ Why?_____

Where? _____ Were X-rays Taken?_____ Date of last Adjustment _____

*PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW*



What is the main reason for consulting our office:

- □ Become pain free
- □ Explanation of my condition
- □ Learn how to care for my condition
- □ Reduce symptoms
- □ Resume normal activity level

Please answer the following questions for ***each seperate area*** of pain you are experiencing:

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

Are your symptoms on one side more than the other? □ Right □ Left □ Central □Both

What is the intensity of your pain at present?

□ None □ Mild □ Moderate □ Severe □ Unbearable

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □Tingling □ Stabbing

□ Tightness □ Stiffness □ Throbbing □Radiating Pain: Where?_____

□ Other:_____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, driving, sleeping, lifting, etc)? Please list below or circle listed._____

What makes your pain better (ice, heat, massage, stretching, movement, rest, etc)?

_____

What is your SECOND complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

Are your symptoms on one side more than the other? □ Right □ Left □ Central □ Both

What is the intensity of your pain at present?

□ None □ Mild □ Moderate □ Severe □ Unbearable

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □Tightness

□ Stabbing □ Throbbing □ Radiating Pain: Where?_____

Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, driving, sleeping, lifting, etc)? Please list below or circle listed._____

What makes your pain better (ice, heat, massage, stretching, movement, rest, etc)?

_____

What is your third complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

Are your symptoms more on one side than the other? □ Right □ Left □ Central □ Both

What is the intensity of your pain at present?

□ None □ Mild □ Moderate □ Severe □ Unbearable

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □Tingling □ Tightness

□Stabbing □ Throbbing □ Radiating Pain: Where?_____

Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □6 □7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, driving, sleeping, lifting, etc)? Please list below or circle listed._____

What makes your pain better (ice, heat, massage, stretching, movement, rest, etc)?

_____